



HELLO

**Welcome to Issue 86, May 2023 edition of
the RCPsych Old Age Faculty Newsletter**

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Cover Artwork

"Watered Down" (2023)

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Inspiration for artwork

"When asked to describe how they feel about their life, an older adult mentioned that it feels like everything around them felt quite watered down, Hence the use of graphite to depict them"



Artwork reproduced with permission from the artist

Edits (06/05/2023)

Page 09 - Correction of spelling of authors name

Page 25 - Correction of author's trust affiliation

IN THIS ISSUE

Issue 86, May 2023

Editorials

- 01 Update from the Editorial Team, Sharmi Bhattacharyya
- 02 View from the Chair, Mani Krishnan
- 03 Newsletter Update, Alistair Burns & Amanda Thompsell
- 20 Call for consultant editors opportunity

Legal Section

- 06 Protecting human rights in care settings. Harvir Sahota & Martin Curtice

International Section

- 09 Older Offenders - Way to Move Forward. Muthumathi Swamenathan
- 11 Challenges in Assessing Cognitive Functions in Elderly in India. A Bio-Psycho-Social Viewpoint. Shreenila Venkatesan & Nivedhitha Srinivasan

Features

- 14 Psychiatry and Palliative Care. Dr Katy Somerville
- 16 Simulation teaching to manage Old Age in-patient falls. K K Shankar

Case Study

- 18 A Case of Atypical Dementia Alzheimer's Type
Tariq Khan & Harshani V. K. Yapa Bandara

Competitions

- 21 The Old Age Psychiatrist Newsletter Essay
Competition Results 2023
- 22 Winner - Ellena Sheldon
- 25 Runner Up - James Barclay
- 27 Third Place - Audrey McBride
- 30 Medical student essay prize in Old Age
Psychiatry 2023 Winner - Sarah Shah

Review

- 42 TV Review - Still Game, Anitha Howard

Trainee Focus

- 43 Welcome, Lizzie Robertson & Becky Fitton
- 43 Old Age Psychiatrist Trainee Editor opportunity
- 44 "Higher Trainees: The clinical leaders of the future
Rebecca Fitton and Elizabeth Robertson





Update from the editorial team

Hello again from the Editorial Team. Hope you are all keeping safe and well.

Helen, Anitha and I have been the editorial team for the newsletter from 2015 so we think its time, we advertise for new Consultant recruits to join the Editorial team. Please read the advert and express your interest via the College Managers email or through the newsletter team. It has been an interesting and fulfilling 8 years and we have enjoyed leading on the Faculty newsletter and working closely with Executive committee to source articles of interest and updates.

Going forward, in this May 2023 edition we have our usual updates. The Chair's report highlights all the current relevant issues.

The update by Dr Amanda Thompsell, the National Specialty Advisor (NSA) for Older People's Mental Health (OPMH) at NHS England/NHS Improvement and Prof Alistair Burns as always provides food for thought.

If you are interested in legal aspects, there is an informative article by Dr Curtice. This edition also has an international section on articles from

India and Malaysia. The Trainees section is developing thanks to our trainee reps and our Trainee Editor.

The Newsletter essay competition has been judged – the title for this year's competition was 'Can we live and age as who we truly are? The future of equality, diversity and inclusion'. The top three essays are published in this edition. This edition also has the Medical student Essay prize winners submission. Dr Howard as always has provided an interesting review on a TV programme. The next newsletter is September 2023 and will be dedicated to a special edition on Memory Assessment Services so please feel free to send dedicated articles on the email below. The last date for submission is 31st July 2023.

As always let us know what you think of the newsletter, and feel free to email me on drsharmib@gmail.com with ideas, suggestions and of course articles for the future newsletter. We look forward to expressions of interest in joining the Newsletter Team.

Dr Sharmi Bhattacharyya
Lead Editor



View from the Chair

Dr M S Krishnan (Krish)
Chair of the Faculty of
Old Age Psychiatry



@deliriumkrish

Dear colleague

Hope you are well and many of you attended our faculty annual conference. Unfortunately, due to train strikes we had to quickly move the Hybrid event to fully online conference. Our apologies. We were so looking forward to meeting and networking with colleagues in London.

We had 496 delegates registered for the conference. Those who were registered will be able to access the online recording and resources for 2 months. Thanks to our Academic secretary Dr Chineze Ivenso and her team of exec members who had put together an excellent program.

Hopefully we will have that opportunity in 2024 annual conference. Probably in April (to avoid easter holidays – will share the dates once confirmed)

It was also lovely to see some of our faculty members at the Hybrid winter conference we jointly hosted with our liaison faculty.

We had another strategy day with our faculty exec meeting in February and continued our discussion on the topics.

- 1.Memory clinics
- 2.CMHT and SMI, functional illness
- 3.Research/new treatment
- 4.Raising profile/interface/engaging with other organisations
- 5.Education

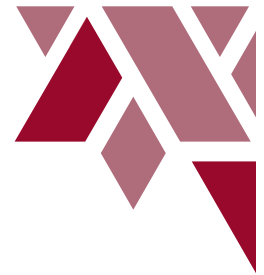
Congratulations to Dr Sharmi Bhattacharyya, our newsletter editor who was appointed as Chair of Welsh faculty. I would like to thank Sharmi and her editorial team for a wonderful job since 2015 managing and updating the newsletter to this current version. Please see a separate advertisement for expression of interests to join the newsletter editorial team. Our September edition will be a special edition on Memory Assessment Services please send your articles.

Please continue to engage with our faculty twitter page @RcpsychOldAge.

Newsletter Update

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The Older Adult Mental Health Update

At the centre within the NHS and DHSC hierarchies there is now a strong realisation that in the light of rapidly changing demographics there should be an increased focus on older adults and how we can support them to live healthy lives.

This presents those of us involved in the field of older people's mental health with a unique opportunity to get ourselves, and the voices of older adults, heard at local level, where operation planning and budgets are determined.

A key resource in this regard is [NHSE's 2023/24 priorities and operational planning guidance](#). This states (at page 6) the NHS's key objectives and that they include objectives:

- Of increasing older adults' access to IAPT - now the talking therapies for depression and anxiety offered by the NHS; and
- of achieving a 5% year on year increase in number of older adults (and adults) supported by community mental health services.

Another key resource in this regard is NHSE's Delivery Plan for Recovering Urgent and Emergency Care Services.

This includes many points that those involved in older adults' mental health services should be aware of. I would highlight in particular:

- the plan that next winter that there should be expansion in joined-up care for older people living with frailty, including scaling urgent community response, frailty and falls services across the whole country;
- the advocacy for the greater use of 'virtual wards', with a reference to "open-access age-appropriate services" which meet local population needs;
- the proposals for scaling up intermediate care: by autumn 2023, NHS England will develop a new planning framework and national standard for rapid discharge into intermediate care, building on the learning from the front runner sites. As Alistair has already mentioned the Major Conditions Strategy due in the summer-shifts to an "integrated, whole-person care," with specific focus on mental health as well as dementia and health inequalities.

All of these initiatives involve older adults in particular.

On the topic of frailty, I should highlight also an excellent resource by the BGS called [Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf](#). This is aimed at ICBs. It has recommendations that will benefit those older adults with mental health needs as well as those with physical health needs and dementia and is well worth a read.



Update for the Newsletter

A complaint that I heard at the Faculty conference related to delays in discharging from the inpatient ward. I can reassure you that older adult inpatient wards have not been excluded from the many initiatives to reduce delays in discharge and I would like to bring two to your attention. The policy of joint planning, commissioning, and delivering of services between the NHS and local authorities includes the aim of providing more investment in mental health accommodation-based support that can meet people's needs and reduce the delays in discharges from hospital.

Importantly this policy applies to older adults. Details of what is involved in planning and obtaining funding for such support are included in an excellent resource pack developed with key stakeholders (LGA, ADASS, HACT etc) available at [NHS England National Adult and Older Adult Mental Health Programme - Future NHS Collaboration Platform](#).

Patients in mental health inpatient units (including older adults) , who are clinically ready for discharge but awaiting assessment or decision about their longer term care package, can also be considered for a step down placement under the Hospital discharge fund where appropriate [NHS England » Hospital discharge fund guidance](#).

While I am discussing information resources, there are several other resources that are going to be available at the end of April 2023. These include two webinars, one on ensuring that the voices of older adults with lived experience are heard in service design and the other deals with how to establish and make the most of "peer support" for older

adults . The National Team has also just commissioned training for Tier 1 and Tier 2 staff in depression and self harm in older adults. This is expected to be available at the end of 2023.

The following webinars can be accessed using the links below:

- [OAMH Webinar - Lived Experience - Future NHS](#)
- [OAMH Webinar 0 Enabling Peer Support in Mental Health Services for Older Adults - Future NHS](#)

The National Team continues to strive to ensure that the interests of older adults with mental health issues are not forgotten when wider policies are being developed. We now have older adult clinical representation, thanks to Faculty colleagues in all the Mental Health Currency model working groups so that the complex needs of older adults can be taken into account. The National Team also has a statistical expert who is going to look at the various dashboards based on provider level data (which continue to proliferate) to ensure that the data can be broken down by age so that we can see what is happening to older adults.

As many of you will be aware, outcome measures are being rolled out as part of the Community Mental Health Transformation. The National Team has been involved with this and the implementation guide is currently under development and is expected to be completed by Autumn 2023. I am aware of the concerns expressed about outcomes measure within our profession and I have arranged for some members of the Faculty Executive to discuss their concerns with the National Outcomes Team.

Update for the Newsletter

If there is a theme to this report it is that getting care right for older adults is at the heart of getting the wider system to work effectively. We have always known this but increasingly the NHS at national level realises this too. I believe that old age psychiatrists, with the expertise that they and their team members bring, could not be more needed and at last this is being recognised. The challenge remains to embed this understanding into the structures and funding at the level of service delivery.

Dementia Update

Across the NHS and social care, there is an increasing awareness of the role that dementia plays in almost all settings involving older people. I have been visiting various Integrated Care Boards (ICBs) to highlight this point. At a national level the commitment to dementia care remains strong. Although the long-awaited Dementia Strategy is not now being separately pursued, it gains traction as a key element within the Major Conditions Strategy that is due out in the Autumn, where dementia along with, for example cancer, has its own specific workstream.

There remains much to do. It is a continuing cause for concern that the dementia diagnosis rate has slipped down (a green shoot of recovery in February) but I am seeing many innovations at a local level with a view

to increasing the rate and would highlight in particular the excellent DiADeM work (Diagnosing Advanced Dementia Mandate) in care homes.

Of course you can't manage what you can't see and measure. With this in mind, the national Mental Health Team at NHSE have been working on making the Dementia Data Dashboards meaningful so that you can see how a memory service is doing and assist with the benchmarking of performance. Hopefully this will add value to locally collected information.

Whilst improving the dementia diagnosis rate is important we are wary of the danger of "hitting the target but missing the point." There is little advantage in finding disease if we are not geared up to do anything about it. The role of post diagnostic services remains critical.

I remain hopeful of the potential for new disease modifying treatments. The National Team is focused on ensuring that we are well placed when a new treatment becomes available of ensuring that it is appropriately, equally, widely and rapidly introduced.

As always, we would be happy to hear your views and thoughts on national developments so please do not hesitate to contact us.

International Diploma

Call for Advisors, Clinical Experts and Authors

The College is calling for members from around the world to help develop its first international diploma, focusing on Old Age Psychiatry

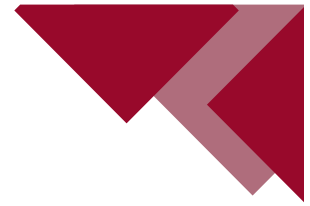
We are in the early stages of development and reaching out for expressions of interest

Please contact International Liaison Coordinator Samuel Smith, samuel.smith@rcpsych.ac.uk, if you are interested in this opportunity



Update for the Newsletter

Protecting Human Rights in Care Settings



**Dr Harvir Sahota – CT2 in General Psychiatry
Coventry and Warwickshire Partnership NHS Trust**

**Dr Martin Curtice – Consultant in Old Age Psychiatry
Coventry and Warwickshire Partnership NHS Trust**

Introduction

The Joint Committee on Human Rights (JCHR) is appointed by the House of Lords and the House of Commons to consider matters relating to human rights in the United Kingdom. In July 2022 the JCHR released a report into its inquiry into protecting human rights in care settings in England¹. The inquiry followed a 'torrid few years for care users: the pandemic caused great suffering and isolated residents from their loved ones'. The inquiry 'sought to shed a light on the human rights most at risk in care settings, and what can be done to better protect them'. The report noted care settings provided services to some of the most vulnerable groups in our society – care settings being defined as environments in which assistance and/or healthcare support is provided to individuals. It further noted 'These are places in which closed cultures can easily develop, potentially leading to harm and to serious human rights breaches'.

In light of this, and given the vulnerability of those looked after in care settings the inquiry set out to consider:

- The relevant human rights issues in care settings.
- How effective providers are at respecting these human rights.
- Effectiveness of regulators in protecting individuals from human rights breaches and supporting complaints against providers.
- Lessons to be learnt from the covid pandemic with respect to preventing future human rights breaches.

The scope of the inquiry was limited to the areas of:

- Provision of care.
- Visiting arrangements.
- Human rights framework.
- Complaints mechanisms.

Care settings 'provide vital services to some of the most vulnerable in our society' and 'can potentially engage a large number of human rights'. The human rights engaged come from:

- Human Rights Act 1998 (HRA) – as the European Convention on Human Rights (ECHR) is enacted in the UK.
- Convention on the Rights of Persons with Disabilities (CRPD).
- International Covenant on Economic, Social and Cultural Rights (ICESCR)



Provision of Care

Residents in care settings often require support in the provision of personal care. Failure to meet these needs risks exposing individuals to degrading treatment and violation of dignity. The inquiry heard evidence from one individual who detailed repeated neglect of her father's personal care. She described her father's death as 'long and cruel'. The national Relatives and Residents Association (R&RA) had concerns regarding provision of medical and personal care, noting one individual becoming 'depressed' because of neglect.

The inquiry noted criticisms had been raised regarding the Care Quality Commission (CQC) in its ability to identify failings when several care settings rated as 'good' were found to be lacking and causing individuals distress. The inquiry noted a 2020 CQC report ('Out of Sight – Who Cares?') reviewing the use of restraint, seclusion and segregation in care services for people with mental health disorders, LD or people with autism. The CQC noted their report found 'too many examples of undignified and inhumane care, in hospital and care settings where people were seen not as individuals but as a condition or collection of negative behaviours'.

Furthermore, 'the response to this has been often to restrain, seclude or segregate them'. The CQC report highlighted the issue of delays in DoLS authorisations (some dating back to 2014!) and subsequent deprivations being without adequate safeguards or legal authority. Of the 17 recommendations the report made to government, none have yet to have been fully achieved.

A failure to meet certain care duties may be contributed to by a lack of emphasis on human rights during training. The inquiry therefore called for the implementation of this consideration into professional development.

Visiting Arrangements

The inquiry highlighted the importance of meaningful contact with loved ones and the impact of restrictions on both the care home resident and their family. One individual spoke of there being 'many wonderful carers, but they do not have my mother's memories'.

Despite appreciation of blanket restrictions on visiting in the wake of covid-19, it was felt that a balance had not been struck owing to too much left to the discretion of care settings and the result has been a breach in the right to private and family life. The inquiry also discussed the speed with which government guidance is updated and how this often contradicts that of the CQC, meaning that there is incongruity in the residents' expectations and the ability of the setting to accommodate.

The inquiry calls on the government to introduce legislation to mitigate against variable application of guidance and meet the criteria of 'in accordance with the law' criteria required to interfere with human rights.

Human Rights framework

Under the HRA, public authorities are required to comply with ECHR rights. However, the Government have introduced the Bill of Rights proposing to repeal and replace it. The requirement on public authorities to read legislation in a manner compatible with ECHR rights is altered under this Bill, the practical application of which may impact the human rights of care users. The inquiry calls for the government to consider the impact of the introduction of the Bill of Rights and the potential for it to weaken the duty of public bodies to protect human rights as previously protected under the ECHR. It asks for the Department of Health and Social Care to publish an analysis with respect to the above.

The HRA is only applicable to public bodies and care funded by local authorities. Therefore, self-funders in private care homes do not have their rights directly protected under the HRA. The inquiry highlights those two individuals in the same care setting may therefore have different legally enforceable rights depending on their funding arrangements, a fact about which the government appeared to be unclear when confronted. The inquiry views the differential nature of enforceability as unjustifiable.

Complaints Mechanism

There is an expectation that service users have access to a complaints mechanism that is 'transparent, fair, and proportionate'. However, it was found that fear of retaliation and the complexity of available mechanisms acts as a barrier in pursuing complaints. Complaints related to the MHA can be escalated to the CQC if not addressed by care providers, those unrelated to the CQC should be escalated to the Local Government and Social Care Ombudsman (LGSCO) or the Parliamentary Health Service Ombudsman (PHSO). The inquiry noted significant confusion regarding the roles of the CQC, the LGSCO and the PHSO in the handling of complaints.

The length of the process involved is a particular barrier to older care home residents as highlighted by the Age UK charity director who noted 'There is no point being embroiled in some lengthy process that does not conclude until after your loved one has died'. The inquiry heard concerns regarding fear of retaliation after some care settings made 'excuses' to move patients on after their management had been criticised.

In addition to the structural issues, the LGSCO told the inquiry that many people lack the ability to complain owing to issues of mental capacity, lack of advocates or fear. The inquiry agreed with the LGSCO that giving them power to investigate without the need for individual complaints would better able them to 'give a voice to the voiceless', as would extending this power to the PHSO.

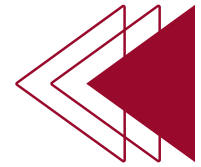
The inquiry raised a concern about the lack of clarity over CQC's responses to complaints. In 2020/21 the CQC received 2280 complaints and concerns about the MHA but only seven were investigated. When questioned as to why such a small percentage (0.3%) were investigated, the CQC explained they 'do not hold the granular data about the individual steps taken in the 2,280 cases' but they did however employ a 'robust, staged process to hold providers fully to account in how they respond to every single complaint we pass to them'. The inquiry proffered that without any data to show what has happened to the majority of complaints and concerns received they 'cannot be assured that the CQC is adequately investigating such complaints'.

Regarding complaints mechanisms, the inquiry concluded these should be 'clarified and streamlined'. They recommend this was done by ensuring all complaints were investigated by the LGSCO or PHSO and not the CQC, leaving the CQC to focus on its monitoring and regulatory role. They advise a 'no wrong door' policy whereby a complaint that is not within the scope of one body must be redirected to the appropriate organisation.

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Older Offenders - Way to Move Forward



**Dr Muthumathi Swamenathan - Medical Officer and Psychiatry Trainee
Hospital Sultanah Aminah, Johor Bahru, Johor, Malaysia**

Older offenders is one of the critical issues over the past several decades, the level of attention directed towards managing aging prisoners has risen substantially. Worldwide researches including from UK indicates countries are grappling with nearly identical issues associated with greying prison population. Without timely attention to the experiences of elderly offenders, officials globally will undeniably be presented with a crisis that in return would negatively impact all aspects of the correctional system.

Despite the fact that nations around the globe are confronted with dilemma of managing increasingly large numbers of older offenders, prisons have been slow to respond to the social, physical and mental health needs of geriatric prisoners. The rationale for this article is to raise awareness of the plight of this category of aging, ailing and cognitively impaired prisoners and to put forward essential recommendations and discuss strategies that are being implemented in some countries. Not to forget highlight on important facts on older offenders to gain insight of their real conundrum in prison.

Generally older offenders fall into three distinct categories. Those who are old when they commit their first offence, those whose offending started when they were much younger- they are called recidivists and those who offended young and have remained in prison on a long sentence. According to researches, most prevailing crimes committed by older people aged 60 and above in UK is sexual offences followed by violence. Alcohol abuse and dependence is a particular problem in older prisoners as well.

Elderly prisoners frequently have concurrent cognitive, emotional, social, interpersonal, behavioural, physical and psychiatric morbidities. The most prevalent mental illness among older offenders in prison population is depression, followed by schizophrenia and psychosis. Surprisingly dementia constitutes about 1% only. The reason for this number probably because impaired executive functioning and planning in dementia make it harder for them to offend. The second reason could be that dementia goes undetected and not assessed adequately in prison. It is beyond doubt that geriatric offenders' physical health, mental health and social aspects of care are often unmet in prison setting.

Mental disorders in older prisoners are often undetected and untreated. Prison often leads to a rapid decline in an older person's health. Accelerated aging in prison exposes and exacerbates their underlying medical and psychiatric conditions. The stressful conditions of prison confinement such as prolonged exposure to overcrowding, social deprivation and violence, further increase the risk of early onset of serious health issues. As they are vulnerable group of people in prison, elderly in prison are exposed to risks of bullying and harassments from their younger inmates.

What are the ways to move forward for the betterment of our aging prisoners? Advocates are calling for more early release programmes for aging inmates. These programmes could allow for conditions that monitor the parolee after his or her release from jail. Conditional release programmes are especially useful for geriatric offenders who pose a minimal safety risk. Aging prisoners release programmes could also prove profitable to prisons and taxpayers.

The physical condition, structure of the prison and activities in prison are designed for young, active people. It can be difficult for older, frailer inmates and particularly for those with limited mobility. There is need for age-specific rehabilitation trainings and activities in prison. Special elderly accommodations and environmental modifications are considered safer than living in the general prison setting. Handrails, lower bunks on main floor tiers, elevated toilets and wheelchair accessibility are few of the important elderly-friendly prison settings.

Development of specialist services such as old-age psychiatry to be implemented in prisons for older offenders. Focus should be managing them as holistically giving importance to their bio-psycho-social needs. Specialized inmate housing system or prison for the elderly is a promising future approach worth explored and adopted for use in enhancing the quality of life of the greying prison population.

As depression is common among geriatric prisoners, a standardised screening assessment or questionnaire is needed for those aged 60 and above in prisons at regular intervals. Geriatric Depression Scale (GDS) is an ideal instrument. Other recommendation is to raise general awareness among all prison staffs of the increased risk of depression and suicide in the older prisoners and to refer if they appear withdrawn or isolated. Educate them about signs and symptoms of depression in elderly such as non-specific and frequent somatic complains can be one of important symptom of depression in elderly.

Upgrading the in-prison counselling and psychological services focused for elderly is crucial too. Programmes aimed for older participants could be age-specific stress reduction, anger management, courses on memory improvement, medication education and management with group-based activities and therapies most likely be beneficial.



Because of high prevalence of physical and mental health illness among older inmates, this group of offenders require more frequent, complex and costly medical services. Correctional budgets need to provide older prisoners with easy and improved access to medical care. It is also standard that geriatric offenders require medical care outside of a correctional facility if they are out on early release programmes. In meeting these challenges, there is a call for further expansion of resources and refunding strategies to be implemented to face the unmet needs of the elderly offenders. This special population deserves special recognition among the policy makers and stakeholders. Basic human rights and the right to be treated humanely despite living in the confines of a prison must be considered for aging incarcerated person. It is inhumane to turn a blind eye to this global problem.

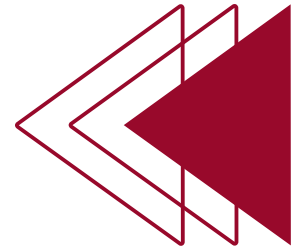
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Challenges in Assessing Cognitive Functions in Elderly in India. A Bio-Psycho-Social Viewpoint

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With improved health, longer life expectancies and low mortality, the elderly population is expected to grow considerably in the next 50 years. As the numbers rise, we also see a rise in the prevalence of dementia, which is characterised by decline in memory, language, and other cognitive functions. In India, there are currently about 5 million people with dementia. However, the diagnosis of dementia is being missed or substantially delayed for the larger part of the population, which results in them missing adequate and appropriate pharmacological treatment and psychosocial interventions.

Early detection of cognitive impairment will help both people with dementia and their families to prepare and plan for potential progression of illness. For a timely diagnosis to happen, relevant cognitive assessments must be done efficiently.

Despite having validated tests and tools, clinicians still face a number of difficulties when evaluating cognitive functions in a heterogeneous country like India, where the population is diverse and has a wide range of languages, educational levels, and cultural traditions. For instance, in Sweden, researchers observed that there were occasions where significant parts of the assessments were skipped and not assessed owing to various causes in regard to language and culture, which is similar to what happens here in India.

This article will focus on the various challenges that we face while assessing cognitive functions from a bio-psychosocial lens.

In our clinic at Dementia Care at SCARF (DEMCARES), Chennai, the cognitive tools that we use include the Vellore Screening Instrument for Dementia (VSID), Montreal Cognitive Assessment (MOCA), and the Alzheimer's Disease Assessment Scale—Cognitive Subscale (ADAS-Cog). All these assessments are validated for use in our population. With this in mind, we'll walk through the various challenges we've faced while using these tests.

Biological factors

Sensory impairment

Vision and hearing impairments are two sensory impairments that are frequently observed in elderly people, which also contribute to the difficulty in assessing cognitive decline. This is mostly because an untreated sensory impairment might cause ambiguity regarding the severity of cognitive impairment. For instance, while attempting to assess for a domain linked to language, an underlying uncorrected hearing impairment may result in either mistakenly detecting a language impairment or neglecting a language impairment when one is present. This is a compelling problem in India, as most older people refuse to wear hearing aids due to the stigma associated with them.

MoCA, a cognitive assessment test modified for blind and deaf people, is one of the options for the Indian population. These tests, however, are only able to gauge particular cognitive domains. When an elderly person suffers from both vision and hearing loss, the assessment gets more complicated. In such circumstances, clinicians struggle with gauging the severity of the illness which also results in making treatment regimens that are subpar.

Physical Impairment

Age-related physical decline can be a hindrance to cognitive assessments. For instance, people who present to the clinic post stroke or with motor disturbance have difficulties holding a pen due to rigidity or reduced dexterity. As most cognitive testing involve paper and pencil tests, this is typically a problem. In ADAS-Cog for example, constructional and ideational praxis are assessed using arranging matchstick designs and folding paper, and writing letters, which can be challenging for people who may not be able to use their hands. This presents a problem when assessing people with Parkinson's disease and other similar neurological conditions.



Psychological factors

In India, people come to the clinic at a later stage of the illness in cases of dementia, usually with some behavioural problems associated with it. At large, a lot of people present with somatic and health related anxiety symptoms that cause a lot of distress and restlessness. Because of this, it takes time to complete the assessment, and frequently, when attention is diminished, there is a practical issue with repeating test instructions, which may result in an inaccurate assessment of cognition.

Certain personalities, particularly those who are authoritarian, tend to get agitated when they are asked questions evaluating cognition and often refuse to even attempt the test.

An outright refusal or disinterest to participate in the examination is common in cases of depression and apathy, and frequently the assessment must wait until the depressive symptoms subside. Though apathy is considered a behavioural indicator for a marked decrease in cognition, it has been an ongoing challenge to assess the level of cognitive decline for someone who presents with apathy.

Social factors

Gender, education level, and language are additional psychosocial factors that influence assessments of cognition in elderly people in India. Even though we have the VSID, which can detect cognitive impairment in uneducated adults, it only goes so far. For the illiterate and those residing in rural areas, there are not enough diagnostic instruments available.

Matchstick design used in ADAS-Cog to assess Constructional Praxis (image)

With respect to our setting in Chennai, the native language spoken by most people is Tamil. The problem arises, though, when speakers of two or more languages combine them in their cultural speech.

In certain circumstances, a combination of two languages must be employed to conduct the evaluation instead of just a single language. Due to the population's heterogeneity, people who speak languages like Malayalam or Telugu cannot be assessed using tools like the ADAS-cog or VSID.

There are a number of difficulties despite the availability of many cognitive examinations tailored to the Indian environment. Furthermore, because the majority of cognitive tests heavily rely on language, it might be difficult to evaluate other cognitive domains in those who have a documented language impairment. Again, this raises questions about proper evaluation. Future research could focus on developing cognitive assessments that can be used for people with multiple sensory impairments. For example, those who are unwilling to cooperate in assessments or those who have severe sensory impairments may benefit from examinations that place more emphasis on observation than questioning. For those who lack education, observation- and carer interview-based assessments can be modified. Existing assessments such as ADAS-cog and VSID can be adapted to other languages that are commonly used in India.

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Call for Articles THE OLD AGE PSYCHIATRIST

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We are looking for a variety of interesting articles including memory services models, innovative practice, trainee and medical student experiences of memory services and diagnosing rarer dementias.



Submission Deadline 15th July 2023

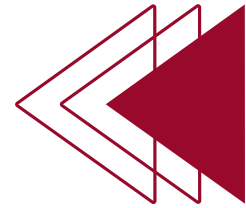
email Kitti.Kottasz@rcpsych.ac.uk with subject "Old Age Psych Newsletter"

The issue will be published in September 2023



Psychiatry and Palliative Care

Dr Katy Somerville
Specialty Doctor in Community Rehabilitation
Dorset Healthcare University NHS Foundation Trust



My experience

I remember one weekend on-call covering the dementia ward as a core trainee. I'd received a detailed handover about a woman with advanced dementia, who was approaching the end of her life and might pass away this weekend. My colleague warned me that there was a lot of anxiety on the ward about this- the situation was relatively unfamiliar.

Luckily, I was a fairly new core trainee. I could remember my time on a geriatric medical ward, where end of life care was commonplace. My weekend colleague had given me a great handover and there wasn't too much for me to do other than 'contain' the situation. However, I felt anxious too. I knew how important end of life care is and I didn't want to get this wrong.

How is palliative care relevant to us?

I've always been interested in palliative care. I think there are many crossovers with psychiatry; communication, patient involvement, addressing the needs of family¹. The biopsychosocial approach is relevant in all of medicine but especially so in these two specialties.

50% of palliative patients cared for at home have moderate to severe symptoms of anxiety or depression in the last week of life². The psychiatrist can be well placed to help distinguish between different symptomatology (does this reduction in oral intake indicate a depression or that the

patient is approaching end of life?) and consider management alongside the treating team (is an antidepressant useful or harmful in this situation?). Liaison psychiatrists also commonly review patients with delirium approaching end of life.

What about old age psychiatry?

It is also particularly relevant for those who work in old age psychiatry to be familiar with palliative care principles. Dementia is a life limiting condition- according to the Alzheimer's Society the average life expectancy for those with Alzheimer's is 8 years, and with Lewy Body Dementia 6 years. Therefore the palliative approach starts from diagnosis¹. It is necessary for those diagnosing dementia to consider advance directives with patients.

At the other end, it is also important to recognise the signs that end of life is approaching and liaise with our medical colleagues when we see these. Experts suggest the final stage of Alzheimer's include the inability to ambulate, speak, and appropriately swallow³. Lunney et al proposed different patterns of functional decline during the last year of life, including a 'frailty' trajectory, which could help recognition⁴. In the US, the 'Center to Advance Palliative Care' has proposed criteria to identify hospitalised patients who would benefit from a palliative care review. This includes asking yourself, 'would I be surprised if the patient died in the next 12 months?', and helps to establish if the patient has unmet needs⁴.

In 2014 the European Association for Palliative care gave specific guidance for those with dementia, including advanced care planning early in the disease process, avoidance of unnecessary interventions, and more research into prognosis and spiritual care.²

How to improve our practice

When caring for someone with advanced dementia on a dementia ward who is approaching end of life, it may not be in the patient's best interests to be transferred to an acute general hospital. If remaining on the ward rather than going back home or to a hospice, it is important for the doctors, nurses and allied health professionals to understand what decisions are being made and why. It may feel shocking to someone without any familiarity with palliative care that we are stopping physical observations, or medications that the patient has been on for years but do not provide benefit in the final stages of life. There may be misconceptions about morphine hastening death.

What struck me during my weekend on call was that having a more formalised pathway for the process would help support the team in caring for a patient who is on the end of life pathway.

Established links with the palliative care community nursing team, the knowledge of when they work and who to call, how the out of hours doctor can access advice from the palliative care medics, what to do once the patient has passed away - formalising this information on paper helps to contain anxiety of the team and support a 'good death'. Recognition of limitations is also important so that other professionals can be involved early on in the process.³



Conclusion

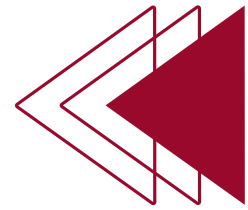
As it was, the weekend went smoothly. The patient's medications had been reviewed and crossed off or added to. The value of physical observations had been considered. Family were up to date and supported, coming in as much as they wished to. The community palliative care nurses were coming in to insert or remove subcutaneous lines. A clear care plan had been written for the team. And critically the best interests of the patient were being prioritised.

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Simulation teaching to manage Old Age in-patient falls

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Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. Falls are estimated to cost the NHS more than £2.3 billion per year. (NICE CG161). Falls in hospitals are the most commonly reported patient safety incident with more than 240,000 reported in acute hospitals and mental health trusts in England and Wales (Royal College of Physicians, 2015).

Most falls are not caused by single risk factor but occur due to interaction of several determinants. Reducing the incidence of falls and as such the harm is a priority for most health services. National Audit on In-patient Falls (NAIF, 2022) recommended inpatients aged >65 should have a high-quality Multi Factorial Risk Assessment (MFRA) regardless of their ward. They further emphasised, there is only one chance to get it right and ensure action is taken following the MFRA to address the risks. Clinical Improvement activities should focus on fall prevention and post-fall management processes.

Simulation-based education is the pedagogical approach of providing students with the opportunity to practice learned skills in real-life situations. (BMC Medical Education, 2016). Although medical simulation is relatively new, simulation has

been used for a long time in other high-risk industries like aviation. Simulations are instructional scenarios where the participant is placed in a situation defined by the teacher to represent a reality within which they interact. The teacher controls the parameters and uses them to help participant achieve the learning outcomes. A simulation is a form of experiential learning. Participants experience the realism of the scenario and gather meaning from it. It allows them to build their understanding of what they are learning through their experiences and interactions, rather than just passively receiving information.

In Hertfordshire Partnership University NHS Foundation Trust (HPFT), the newly developed simulation suite was used to address management of Falls in Old Age psychiatry in-patient units. Three scenarios were constructed following discussion with the ward staff and management. These scenarios were further scrutinised by the local simulation faculty for their feasibility and safety. The three scenarios addressed the learning and addressing the risk factors from completion of Multi Factorial Falls risk assessment, immediate management after a fall including following the trust's the post fall protocol and addressing the concerns of the relative. Four facilitators, including an Old Age Psychiatrist, Occupational therapist, Physical health nurse and an Expert by experience interacted with the participants. Two Professional Elderly actors acted the

scenarios. Facilitators briefed them initially about the learning objective and discussed ways to react based on the different approach participants might take in each scenario. A specialised technician supported the team, with audio/ video equipment, managing the simulated physical health parameters and answered phone calls made by the participants. An educational secretary supported and co-ordinated the programme. The training was delivered monthly for half a day session.

Participants were invited from different Old Age wards in the trust and staff from the multidisciplinary team participated. After the initial introduction to the format, the need for psychological safety was emphasised. Two volunteers from the participants participated in three scenarios. This was witnessed by other participants and the facilitators. The volunteers then re-joined the group, discussions were facilitated amongst them balancing the issues spontaneously arising from the scenarios along with the learning objectives. Relevant leaflets were given in the end for further study in their leisure. Participants were encouraged to discuss their learning in their teams in respective wards. Feedback forms were collected from participants before and after the simulation teaching and also after each

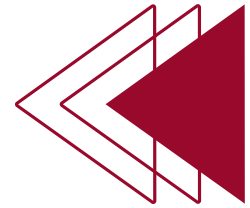
scenario. The overall feedback from the participants and Trust management has been overwhelmingly positive: 'Helpful and very informative', 'It has increased my confidence and knowledge on how to assess manage patient who had a fall'.

Simulation teaching for education of multidisciplinary ward staff improves knowledge of the local falls management protocol. It has increased confidence level amongst a multidisciplinary team in intervening risks for the prevention and management of falls. It also, emphasises using the family member's prior knowledge of the patient in addressing the risks and also having an open and honest interaction with them following an incident. Studies have shown improvements in staff's confidence and knowledge enable improvement in patient safety and experience. There was a one third reduction in the number of falls in the subsequent months after the simulation training. However, this could not be solely attributed to the training itself as there were other initiatives to reduce the Falls incidence started in the Trust at the same time. Nevertheless, Falls Simulation training is a valuable additional tool in reducing in-patient falls in our Old Age wards.

References are available on request



A Case of Atypical Dementia Alzheimer's Type



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Aim

To assess the cognition and mental state of an 84-year-old lady, admitted with reports of anxiety and low mood.

Method

Case history of patient was obtained from e-records, MDT meetings and family. This patient was referred to LPOP team with reports of anxiety and tearfulness following a recent cancer diagnosis with a past history of Mixed Anxiety and Depressive Disease treated with sertraline and propranolol. Initially she had no cognitive impairment, however, during subsequent admission following a fall a few weeks later, in the absence of brain injury patient showed evidence of rapid cognitive decline, with emergence of paranoid thoughts and delusions, difficulty with word finding, time shifting, difficulty concentrating and impaired visuospatial perception. During this 2nd admission, her mood deteriorated further, with worsening anxiety and she also developed supine hypertension. At this juncture, she was scoring 23/30 on MMSE. With a multidisciplinary approach, paraneoplastic syndrome, Parkinson's disease, cerebral strokes, and other differentials were all ruled out. MRI head revealed the possibility of atypical variant of AD (F00.2, Dementia in Alzheimer's disease, atypical or mixed type) with significant frontal and to a lesser extent

posterior fossa involutonal change, and relative sparing of temporal fossa.

With this working diagnosis, the patient was started on Rivastigmine, and 2 weeks later, a drastically different individual emerged no longer plagued by paranoia, or anxiety. She was future oriented, expressing interest in placement as a supportive environment for her in view of her failing health. She was no longer on sertraline or propranolol and family members were supportive of finding a care home able to help her needs.

Discussion

Writing this case study retrospectively, we encountered some gaps in the history that perhaps would have been useful to create a better picture of disease progression in this patient. We surmise that the existence of a common medical record keeping system accessible to all health providing agencies would have mitigated some of these gaps.

The diagnosis of Atypical Alzheimer's disease was made due to the overlap of clinical presentations, and it is worthwhile discussing the known variants. At present, the literature indicates 5 main subtypes^{2,3}, beginning with Amnesic variant of early onset, the commonest, where patients classically present under the age of 65 years with symptoms and signs like typical Alzheimer's Disease (AD).

Two other well described variants include Visuospatial Variant AD, where patients typically struggle with visual deficits including finding objects visible in plain sight, or Balint's or Gerstmann syndrome, and Logopenic Variant AD, in which the main complaints revolve around word finding difficulties, circumlocution and phonemic paraphasia. In both variants, we find relative sparing of other cognitive domains.

Behavioural Variant/Dysexecutive Variant AD and Motor Variant AD appear to be rarer, atypical presentations. The former presents with either prominent difficulties in multitasking, organization, and project execution, or like the behavioural variant of Frontotemporal Dementia, with cognitive decline followed by personality changes.

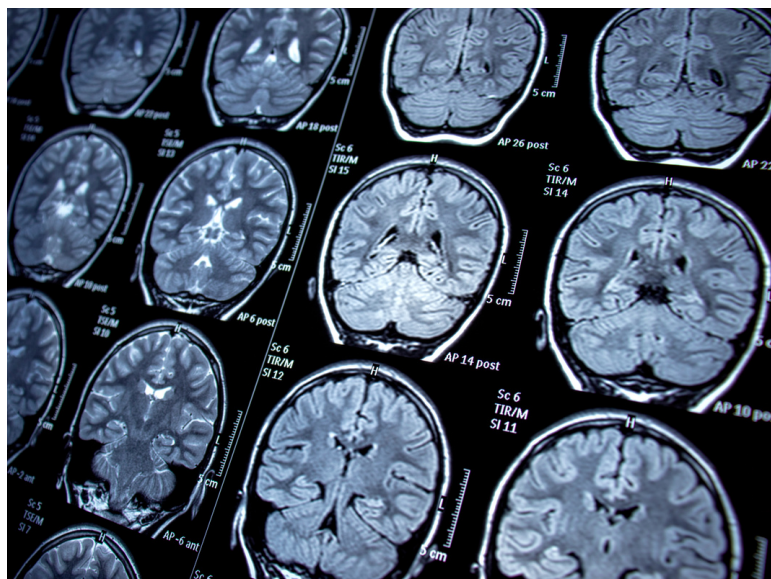
The final variant described is Motor Variant AD, where neurological findings such as Akinetic/rigidity syndrome, and limb apraxia co-exist with cognitive impairment.

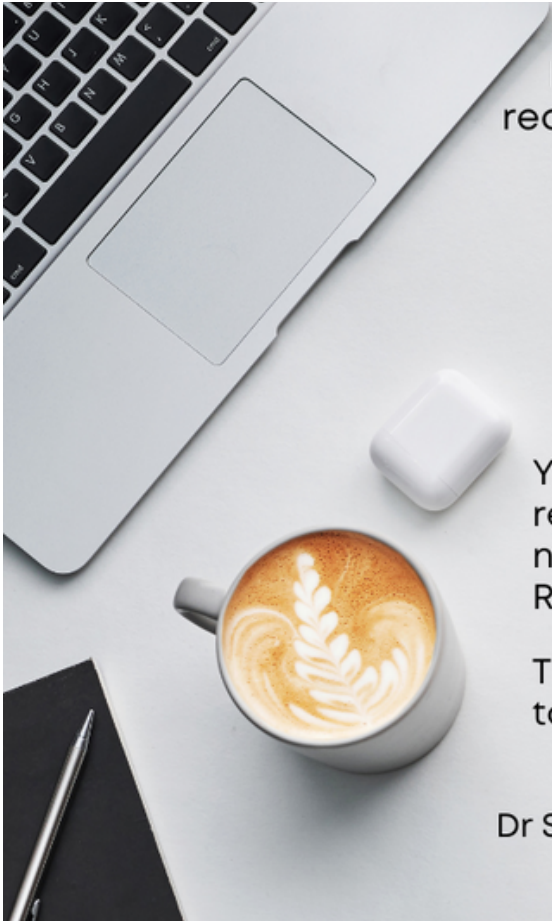
While in each of these variants, imaging and pathology show diffuse brain amyloidosis, each has distinct patterns of tau deposition, neurodegeneration, atrophy and hypometabolism as evidenced by tauPET, and FDG-PET¹. In our patient, we experienced considerable delay in diagnosis due to the atypical onset and progression of symptoms, and it is noted in the available literature that there is considerable symptom overlap which makes distinguishing between phenotypes quite difficult. Further, while the atypical variants are known to be more common in those presenting under the age of 65 years¹, this case study suggests that we should still be mindful of atypical variants in the older adult.

In other countries, it appears that biomarkers are used more commonly in practice to diagnose these atypical variants, whereas in the NHS these are not commonly available, and a more clinical approach is taken towards diagnosis, by focusing on which symptoms are the most prominent and the timeline of onset of each.

Current literature suggests the promising nature of a monoclonal antibody, Aducanumab, but the lack of precise prescribing guidelines and the risk of serious adverse events such as cerebral oedema and haemorrhage precludes its use.

Rivastigmine, inhibiting both Acetylcholinesterase and Butyrylcholinesterase, boosts cholinergic function, and may not only enhance memory, but slow declining cognitive function as well⁴. New evidence from trials also indicates its potential for use in ADHD improving both concentration and attention, and there are studies suggesting its efficacy as an anxiolytic. All these considerations as well as its side effect profile, contributed to choosing rivastigmine, for this patient.





RCPsych Old Age Psychiatry Newsletter are recruiting new members to the Editorial team

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To express your interest please email
Dr Sharmi Bhattacharyya, Lead Editor by 15 June 2023
c/o Kitti.Kottasz@rcpsych.ac.uk

Conclusions

This patient's atypical presentation with visuospatial, language, executive function, attention deficits and radiological findings led us to a working diagnosis of Atypical Dementia, Alzheimer's type. Rivastigmine was used as suggested by guidelines, with good efficacy. We surmise that specific biomarker investigations and imaging will prove useful to distinguish between phenotypes should they become more freely available within the NHS.

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The Old Age Psychiatrist Newsletter Essay Competition Results 2023

Dr Anne M. Bonnici Mallia, Trainee Editor RCPsych Old Age Faculty Newsletter
Clinical Fellow in Medical Education, NELFT
Old Age and General Psychiatry Higher Trainee, Maudsley Training Programme

The title of this year's competition was "Can we live and age as who we truly are? The future of equality, diversity and inclusion." Entrants were asked to write about their thoughts and opinion on Old Age Psychiatry's position in supporting equality, diversity and inclusion.

We would like to thank our three wonderful judges for their time and thoughtful reflection.

Dr Chineze Ivenso is a Consultant Old Age psychiatrist at Aneurin Bevan University Health Board, Newport, Wales and is Academic Secretary Faculty of Old Age Psychiatry, Royal College of Psychiatrists. She is passionate about developing memory assessment services which will provide accessible and outstanding mental health provision to patients and families.

Dr Katie Law is a retired General Practitioner who worked in Aldershot for the majority of her career, moving into medical education for the latter part of her career. She enjoyed the aspect of continuity of care which was particularly important when caring for older adults as their role in society and their own families was changing. She taught at St George's medical School London, both in the department of General Practice and basic medical sciences. She was a medical student examiner with relevant to communication skills as well as general knowledge.

Dr Helen McCormack is a retired Old Age Psychiatrist, who has been one of the Old Age Psychiatrist Newsletter Editors for eight years. She also works for the Mental Health Tribunal and the Medical Practitioners Tribunal Service, and outside work loves to grow plants, engage in a range of handicrafts, and is an avid reader.

The judges recognised the high quality and standard of the entries received for this year's competition. We will be printing the top three entries in this edition of the newsletter and plan to publish two more honorary mentions in the next edition.

Congratulations to this year's competition winner **Dr Ellena Sheldon** CT3 in Psychiatry and Academic Clinical Fellow in Older Person's Mental Health; and runner up **Dr James Barclay** ST5 in Dual General and Old Age Psychiatry

The Old Age Psychiatrist Newsletter Essay Competition 2023 - Winner

Pip and his Grandpa Panda

Dr Ellena Sheldon

**CT3 in Psychiatry & Academic Clinical Fellow in Older Person's Mental Health
Cornwall Partnership NHS Foundation Trust**

Foreword

I wrote this story following a year working in older person's mental health. It also draws on my own experience with my grandmother who sadly passed away from corticobasal degeneration. I have fond memories of sharing our favourite chocolates together every time I visited; something we did from when I was a little girl, until she passed away in my early 20s. I have attempted to create a story that grandparents and parents can use with small children to encourage them that older adults with neurodegeneration conditions, such as dementia, still have a role in our lives, and that we can still connect with them in meaningful and touching ways even as their illness progresses.

Chapter One

Grandpa Panda and his Grandson, Pip the Panda, loved going on adventures together.

In springtime, Grandpa Panda used to take his grandson Pip to find the biggest, most muddiest and splashiest puddles. Pip would jump and run and twirl and splash until all his white fur turned brown!

In the summertime they journeyed to the beach. They built sand castles and decorated them with shells, seaweed and anything else Pip could find! Cooling off by running into the sea and jumping over the crashing waves.

In the autumn Grandpa Panda took Pip to his favourite blackberry picking spots. Pip crunched and stamped in the crispy autumn leaves as they strolled down the country lanes together.

Grandpa Panda was the expert blackberry picker and Pip was the expert blackberry eater. Pip would always return home to mummy Panda with purple cheeks and purple paws.

In the winter Grandpa Panda and Pip loved to stay at home, with the fire roaring, warming their paws. They enjoyed reading books, doing jigsaw puzzles, and playing hide and seek!

Wherever they went, and whatever they did, Grandpa Panda always packed a blackberry jam sandwich with homemade lemonade. This was their absolute favourite snack. "yummmmyyyy". Pip and Grandpa Panda loved the sour taste of the lemonade and always make each other laugh by seeing who could pull the best sour lemon face.

As time went on, and the seasons past by, Grandpa Panda got a little older. He ran a little slower, his glasses got a little bit thicker, and he started to become a little bit forgetful. But he still continued to enjoy his adventures with Pip.

Chapter Two

In the springtime, Grandpa Panda and Pip went to find some muddy puddles. When they arrived Grandpa Panda had forgotten their wellington boots and so they had to go home without jumping in the puddles.

In the summertime, they went to the beach but Grandpa Panda forgot the bucket and spade. They still loved splashing in the sea.

In the autumn time, they went blackberry picking but when they got home they discovered Grandpa Panda had forgotten his keys and Pip had to climb through the window to let them back into the house.

One day in the wintertime, Grandpa Panda got very upset because he couldn't do the jigsaw puzzle. He got cross and shouted out loud. Then, he sat down in his armchair and closed his eyes. Grandpa Panda looked a bit sad. Pip wasn't sure what to do, but after thinking for a moment, he had a good idea!

Pip got out the blackberry sandwiches and homemade lemonade. Grandpa Panda opened his eyes and smiled. "I'm sorry I got cross" he said, and they had a cuddle and Pip replied "It's okay Grandpa, getting old must be very tricky." They sat in front of the warm fire and smiled as they enjoyed their favourite snack. Pip's eyes wrinkled and Grandpa Panda's lips smacked as they finished their homemade lemonade.

Chapter Three

More years passed and Grandpa Panda began to forget more things, and this made him cross and sad. He forgot to light his fire and some days he got very cold. Sometimes he forgot to have dinner. Once, Grandpa Panda forgot where he lived and his neighbours had to help him find his way home again.

Grandpa Panda even began to forget Pip's name and this made Pip feel very sad. He was worried that Grandpa Panda might forget all the fun adventures they had gone on together.

One day a doctor visited Grandpa Panda. He asked mummy Panda and Pip lots of questions about how Grandpa was feeling, and some of the things he'd been forgetting to do. After a long conversation, and lots of thinking, the doctor told them that Grandpa Panda has dementia.

"What's dementia" said Pip to the doctor. "That's a very good question Pip," said the doctor, and he explained "Dementia is a word we use when some people become very forgetful, and sometimes it gets so bad people can no longer look after themselves properly. It affects everybody differently. I'm worried about your Grandpa because he has become cold, hungry and tired at home, and I think he might be happier living somewhere else."

The doctor helped everyone to find a nice new home for Grandpa Panda, where he always had hot food and other animals to talk to. It was a very big house, with very big beautiful garden. There were other animals there to look after Grandpa, called carers and nurses. Pip looked forward to visiting his Grandpa there.

Chapter Four

The kind nurse showed Pip to Grandpa Panda's room. He had photographs up of all his adventures with Pip and he was smiling at them. Pip sat on Grandpa Panda's bed, he didn't say anything, because he didn't need to. He got out some blackberry jam sandwiches and homemade lemonade. Grandpa Panda smiled and looked at Pip. They sat together and munched down their blackberry jam sandwiches, and slurped down their homemade lemonade. As they finished, Grandpa Panda smacked his lips and Pip screwed up his eyes and stuck out his tongue. Sweet and sour homemade lemonade! They both laughed and smiled.

Every time Pip visited his Grandpa they would share their favourite treat of blackberry jam sandwiches and homemade lemonade, and this would help them to remember all their fun adventures.

The End



Illustration by Zara Kolasinska

The Old Age Psychiatrist Newsletter Essay Competition 2023 - Runner Up

Can we live and age as who we truly are? The future of equality, diversity and inclusion

Dr James Barclay

ST5 in Dual General and Old Age Psychiatry

Hertfordshire Partnership NHS Foundation Trust

In November last year, headlines were made when Ngozi Fulani, a black British charity boss, was repeatedly asked where she was “really” from by Lady Susan Hussey, the late Queen’s lady-in-waiting. As various commentators explained, this question – ostensibly neutral – when directed at British people of minority ethnic backgrounds, can mask a more sinister underlying message: “you cannot possibly be British”. Lady Hussey apologised and has since resigned. The relevance of this episode for our purposes is as follows: old age psychiatry is also in the business of finding out “where our patients are from”, not by insensitive questioning that leaves the patient feeling disempowered, but through empathetic enquiry into their formative experiences and relationships, family history, beliefs, values and sociocultural context. Only through this understanding can we find effective interventions for our patients. This essay will make the case that if old age psychiatry is to embrace equality, diversity and inclusion, it must return to basics: namely respectful therapeutic alliances, with patients being treated as individuals and placed at the heart of their care.

The consultant psychiatrist Dr Russell Razzaque has argued that “the relational pillar has atrophied” within mental health settings. Against a background of reductions in funding and staffing crises, the current care climate prioritises rapid throughput and briefer episodes of care, arguably relegating the therapeutic relationship to an afterthought. This effect may be

exaggerated in older adult services. Patronising communication towards the elderly in clinical settings (or ‘elderspeak’) can hinder good clinician-patient relationships. Doctors can be guilty of excluding older patients from medical decision-making, turning to relatives instead. In a study that presented doctors with two identical depression case histories – one in a younger and one in an older patient – the older patient was more likely to be diagnosed with dementia or a physical illness whilst the younger was correctly diagnosed. The same study found that older adults were less likely to be referred for specialist treatment. The combination of poor communication with ageism within psychiatry is demonstrably incompatible with fairness, inclusion and good quality care.

Of course, ageist stereotypes are not restricted to healthcare. Despite there being more people than ever before in older age groups in the UK, ageism remains rife in our society. The ubiquity of “anti-ageing” products within the beauty industry illustrates this well. To return to the episode referenced above, various commentators attempted to defend Lady Hussey by pointing to her advanced years (she is 83), insinuating that problematic behaviour around race was somehow to be expected from the elderly. One consequence of negative societal stereotypes about ageing is that the patients we see in our clinics will inevitably hold biases, conscious or otherwise, regarding their

own advanced years, a phenomenon known as self-stereotyping. There is research to indicate that participants with negative beliefs about ageing die on average seven and a half years earlier than those with more positive beliefs and are more likely to develop dementia. Psychiatrists have a responsibility to understand the sociocultural influences acting upon their patients, while never losing sight of the uniqueness of the individual sitting in front of them.

Capturing our patients' sociocultural contexts within case formulations, including instances of carer strain, will also help us to find meaningful interventions. We live in an increasingly socially disconnected age and for many of our patients, loneliness will be a factor in their mental health presentation. The elderly are at particular risk due to the life stressors potentially encountered alongside ageing including retirement, bereavement and loss of hearing and vision. Spouses or partners of elderly patients may experience a higher degree of carer burden compared with working age adults due to their increased vulnerability to frailty and ill health themselves. The RCPsych equality, inclusion and diversity policy highlights a form of discrimination called "direct discrimination by association" whereby an individual is treated unfairly due to their association with someone with a characteristic protected under the Equality Act 2010 and indeed a recent study looking at stigma in dementia caregiving found that over two thirds of family carers reported a degree of social ostracism due to the health needs of their loved one. At the level of major mental illness, there has been growing interest in approaches such as "Open Dialogue" which emphasise consistently involving the patient's core social network in treatment. Such approaches do not appear to have been widely trialled in the elderly population so this may be a promising avenue for the future.

An eye to context in psychiatric assessments can help to identify and address areas of difficulty in the system around a patient, as well as harnessing the system's strengths. We are of course working in an imperfect system, and many of the system's shortcomings are a consequence of unprecedented strain within both health and social care settings. Any innovation will require creativity at an organisational level. In my own practice I have seen inspiring examples of collaboration between NHS and third sector organisations such as Mind's "Stepping Stones" scheme in Hertfordshire, which allowed volunteers to support inpatients through the discharge process by assisting with social care queries and signposting to sources of community support. This feels particularly relevant for older populations who can feel excluded by modern systems requiring access to smartphones or computers. Old age psychiatrists should also be outspoken in championing primary care social prescribing programmes that link patients with community resources, not as a substitute for existing treatments but rather as a complementary approach.

In summary, we must once again place relationships and communication at the heart of our values base as a profession, while raising awareness of the impact of ageist stereotypes in healthcare. Alongside this we must ensure our interventions make use of the resources to be found within our patients' family systems and communities. In this way we can create a future for old age psychiatry experienced by patients as truly fair, inclusive, empowering and embracing of diversity.

References are available on request



The Old Age Psychiatrist Newsletter Essay Competition 2023 - Third Place

The Apple Tree

Audrey McBride

Year 2 Medical Student

University of Exeter Medical School

The Apple Tree

It is not true to tell you I feel calm
that it might end here: this speckled linoleum,
alcohol tang, yellowed patch, moulded gum.
Mewling and puking in the nurse's arms,
turned over, tucked in tight pink pyjamas
rotated around the panopticon,
fed blended porridge, prunes or tinned pale plums
and with benevolent smiles embalmed.

Baboo, cu cu choo, alright my lovely?
When I was a child, I spoke like a child.
Do I speak to you as a child speaks now?
Transmuted- a fixed harbinger, sweetied
and swaddled: my years are recompiled
whilst the instruction rings out to sit down.

The instruction rings out to sit down and
accept: the value of a wrinkle is the price
of its erasure; of virtue or vice,
no sign will survive the best needled brow.
Lines from smiles, frowns, laughs are all disallowed
only smoothness and plumpness will suffice
in the infinite mission to sharply splice
our years from ourselves, our stern from our prow.

If I had gnarled, instead, like elder wood,
or - shrunk, like the pine that lines the hallway.
If I had ripened as barrelled grapes do,
answered time and time withstood, the best I could,
would you still say: I only see decay?
Imagination, so stifled by taboo.



The shining morning face, spying the knees,
finds places: sloping hills for finger skis
with extra folds for bold jumpers who
land in well-stacked pillows, steadily renewed
by life. Creeping snails better see the beauty
in repatterning shells and with glee
trace the lacy grace of webs and sinews.

The moon assumes its milky fullness
as eyes do, in the cycle of time.
When the lunaria becomes translucent,
we recognise, anew, its brightness –
mingle it with dried berries and lime rind:
the silver dollar is never spent.

The silver dollar is never spent,
reloaded whilst the pennies tumble out,
the jukebox played and we swung about,
sighing like furnaces, tongues fizzed with sherbet.
Elnett hairspray seals those days, its scent
hangs – Pa sits, snores like the crowd on home day, stout
in hand, suds-topped as the pond post-drought
rushed by children, on dunks and dips intent,

racing the shimmer of dissolving sun
and in winter tracing its border with
cautious pads, sliding on to the ice, knees
a quiver, rolling breadcrumbs out of buns
for the ducks and moorhens, please forgive
me – I heard you – ‘sometimes they have great stories’.

Yes I heard you, ‘sometimes they have great stories’.
Well these are my tales; take them as they are.
Neither adventurer nor inventor,
mountaineer nor pioneer – no disbelief
need cross your face as I divulge my diaries.
I’ve never met any Hollywood stars
or travelled afar, driven getaway cars.
I know I’m not overtly noteworthy.

And yet so much depends on a red wheelbarrow;
there rests the difference in richness and wealth
and if neither can be carried on,
we’d do well to let the difference narrow,
and be as equal now in our true selves
as we will be equal when we are gone.



We will be equal when we are gone,
but right now spring air streams through the hedgerow,
a leaf trails my foot and a bird chirps hello –
all these secret moments are stumbled upon
by walking under this morning's golden sun.
So if I must sit down, knees under throw,
let me turn my head towards the window
and see how the blossom has just begun

to bud on the apple tree by the pond
and let me count the ways that I love the
man that tends quietly to its fresh growths.
We are every minute and each second,
not just the first kiss but also today's
and I'll fall asleep dreaming of tomorrow's.

It is not true to tell you I feel calm –
but keep me in temper, I would not be mad.
The instruction rings out to sit down –
still we walk as we walked, less by sight than faith.
Imagination, so stifled by taboo –
has fallen down, down to the silent tomb.
The silver dollar is never spent –
pouring unto us from the heaven's brink.

I heard you - 'sometimes they have great stories'
thus ends this strange eventful history:
as we will be equal when we are gone,
I don't fear whose toes I might step on,
when I say I'm me, I'm free and living,
with bite, with sight, with taste, with everything!

Note from the author

This poem tries to answer the questions: is aging frowned upon, can we live and age as we truly are, how can Old Age Psychiatry support equality, diversity and inclusion? It is culturally embedded, as aging is, and in this sense is driven by some of philosopher Clare Chambers' arguments in her recent book *Intact: A Defence of the Unmodified Body*, including her observation that what we define as natural depends on culture.

Its seven sonnet form is inspired by Shakespeare's 'seven stages of man' from *As You Like It* and its content both reflects and inverts the passage. It also borrows lines from canonised works on aging such as John Betjeman's *On a Portrait of a Deaf Man*, to explore how ideas of aging are culturally entrenched.

The speaker addresses healthcare workers several times and lines from these passages such as 'sometimes they have great stories' are drawn from observations I made whilst working as a healthcare assistant. Although the care and attention that patients receive is overwhelmingly kind and dignified, persistent prejudice and misunderstanding can lead to the rapid disablement and depersonalisation of elderly patients and I saw this happen many times.



Medical student essay prize in Old Age Psychiatry 2023 - Winner

Stratified Medicine and Inclusivity: The Integrated Roles of Translational Research, Clinics and Policy in Future Prospects for Dementia

Sarah Shah

Year 2 Medical Student, Magdalen College, University of Oxford

1. Introduction

As one of the major causes of disability and dependency in the elderly, dementia requires care on physical, social, economic and mental levels. With 55 million people currently living with dementia worldwide, and almost 10 million additional cases each year, the disease burden is ever increasing and requires strategies of management and potential treatment, both for the individual and as a society. Novel therapeutics targeting specific neurodegenerative biomarkers may usher an era of Stratified Medicine into old age psychiatric care and the Memory Clinic, as defined by the use of subgrouping patients to deliver appropriate and individualised treatment. Considering the often multifactorial nature of old age psychiatry, demonstrated by physical, pharmacological and psychiatric comorbidities, this approach appears particularly relevant to improve prognosis. While the concept of stratification is currently gaining popularity due to its successes in other fields, memory services arguably are already offering simpler forms of subgrouping and 'stratification' in diagnosis and therapy, which can be seen in the differentiation between Alzheimer's, vascular, frontotemporal and Lewy body forms of dementia, as well as in principles such as 'start low, go slow' when initiating drug therapies for the elderly specifically. However, further neuroscientific discovery of cellular and genetic targets for stratification would enable the increased specificity required for a truly precision approach to dementia. Questions surround the likelihood of achieving this; even putting research elements aside, clinical and societal problems still arise. Namely, the potential ethical baggage of such data-intensive and patient-centred promises, alongside the ability and limitations of memory services to adopt such models: at this moment in time, only 6% of psychiatry services are able to fully meet the NICE guidelines for biomarker-based Alzheimer's diagnostic testing, with only a further 36% being able to adapt to deliver such treatments within a year.

Therefore, although the potentials of stratified medicine

in dementia are yet to be realised, perhaps it is more important at this stage to ensure that these potentials (or any alternatives) occur in a way that is well-informed, ethical, inclusive to and equally accessible by all. In this essay I will examine the implications of research in dementia care, in light of the amyloid hypothesis and lecanemab trials and the role of novel experimental methodology in informing diagnostic and pharmaceutical targets. Comparing this to observations across varying levels of dementia care with differing priorities, including a Memory Clinic, an Elderly and Rehabilitation Ward and a Revitalise Respite Holiday environment, I will comment upon the disconnect between neuroscientific and clinical perspectives to assert the importance of the clinician and the carer. Upon synthesis of these two seemingly distinct, yet inherently interconnected categories, I will present the role of translating and integrating research into patient care, facilitated by socioeconomic policy. This is shaped and informed by both subsequent factors, while acting to regulate the standardisation and implementation of methods and highlighting potential areas of inequality to be accounted for. In analysis of recent literature alongside my own thought and observation, I propose a model for a Dementia Inclusive Society which is underpinned by the integration of research, clinical care and socioeconomic policy at every stage. This model therefore serves as a sustainable framework upon which further advancements may be made in the field, starting from the adoption of translational neuroscience while ensuring optimal quality of life for patients in the time it takes to reach these goals. Accessibility and inclusion of patients and carers enables their views to be heard, and acceptance and consideration at every stage enables health and social care to exist within and serve society, rather than in isolation of it, to promote an environment that is friendly and supportive towards dementia care. While our magic bullets for dementia may be on the horizon, we must not ignore the strategies in which we can move closer towards dementia inclusivity everyday

2.1 Population-Based Genomic and Healthcare Information Provide the Basis For Preclinical Hypotheses, as Seen in Monoclonal Antibody Development

Recent news headlines have put monoclonal antibody therapies targeting amyloid pathways into public eye, stirring up controversy. The aducanumab controversy resulted from differential performances in identically-designed EMERGE and ENGAGE trials, however was later explained by potential differences in high-dose exposure and placebo group performance. Despite contentions, aducanumab was approved as the first disease-modifying treatment for Alzheimer's disease (AD) in the US in 2021, yet remains unavailable in the UK and Europe, highlighting an area for potential global collaboration in the cohesive standardisation and regulation for such pharmaceuticals. As some have suggested the need for further investigations, it is also important to consider the implications controversy may have on public perceptions of therapy and the impacts of this on future developments both in terms of patient trust, and cooperation of volunteers for clinical trials.

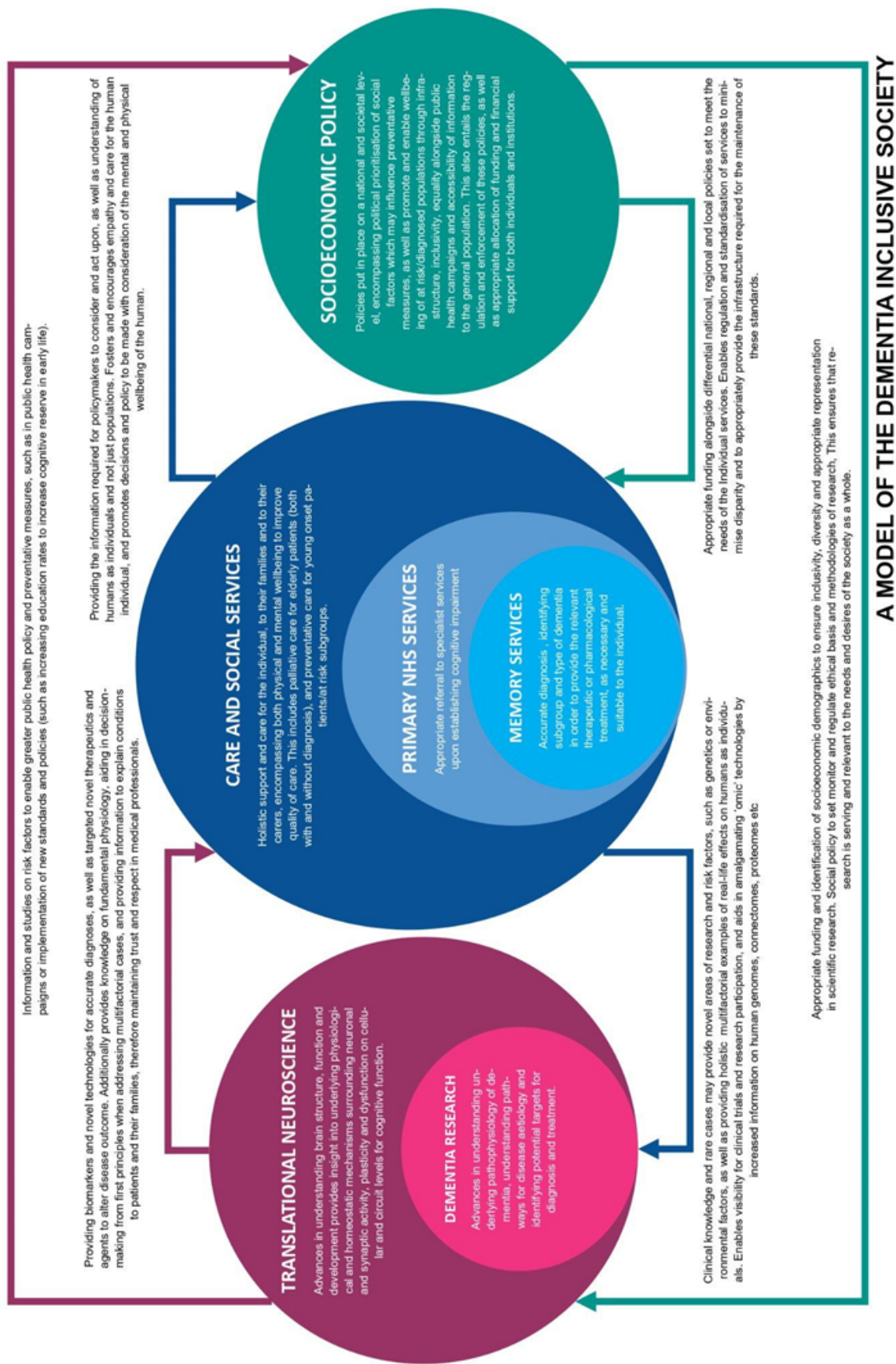
The current lecanemab Phase III clinical trial is faced with skepticism, due to its presumption of being another failed therapy to follow predecessors, alongside concerns surrounding cerebral haemorrhage and/or oedema. However, if this therapy does succeed, it would have implications on clinics and research; what approaches and targets were taken this time and not last time, emphasising that differences between efficacious and non-efficacious results may be the precision and specificity of the monoclonal antibody target. In lecanemab's case, this humanized IgG1 version of the mouse monoclonal antibody mAb158 selectively binds to soluble amyloid-beta ($A\beta$) protofibrils, as shown experimentally by transgenic mice models. Population-involved policy provided genomic data for targeted clinical intervention, largely enabling a mechanism of stratified medicine. The Tg-ArcSwe model utilises the human amyloid precursor protein (APP) gene containing both Swedish and Arctic mutations. The KM670/671NL Swedish mutation increases $A\beta$ levels. In contrast, Arctic E693G mutation carriers' presentation of decreased $A\beta_{42}$ and $A\beta_{40}$ levels, alongside increased protofibril formation, provided the novel therapeutic target for lecanemab: moving away from the plaques and towards the $A\beta$ protofibril. Large-scale comprehensive genealogy studies therefore can form the basis of novel preclinical trials

demonstrating the role of clinical and socioeconomic factors before research can even begin..

2.2. Stratified Biomarker Research May Elucidate Potential Mechanisms for Pathophysiology.

These strategies and targets for potential research and therapy are based upon the amyloid hypothesis, however no definitive causal pathophysiological mechanisms have been defined as of yet. The proposed mechanism for the amyloid hypothesis presents abnormal $A\beta$ production pathways, resulting in aggregation and deposition into amyloid plaques. These then interact with cell types and structures within the brain (vessels, neurons, microglia). The plaques, alongside accumulation of paired helical tau filaments, were first shown to correlate to AD and its progression as a result of Alois Alzheimer's novel fixation and staining methods on brain histology. In post-mortem examinations of a 50-year-old woman who presented with cognitive impairment, observation of senile plaques and neurofibrillary tangles led to the formal categorisation of AD as a disease. Alzheimer's hypotheses and analyses relating cognitive impairment to catabolic products demonstrate the use of biological markers to guide potential theories for disease aetiology. This approach persists, with the hypotheses derived from such laboratory biomarker testing influencing up to 70% of clinical decisions, and demonstrates the importance of basic scientific research in informing clinics.

However, not only is there a lack of unambiguous proof of such mechanisms, but there is also a lack of insight into regulatory feedforward and feedback signals which may play a role in modulating or altering patient physiology and cognitive function. Furthermore, hypothesis does not exist without contention, as alternative schools of thought present the soluble $A\beta$ oligomers as causative molecules for pathology, instead prescribing plaques to preventative roles as reservoirs. Therefore, potential therapy targeting plaques may result in iatrogenic consequences by release of harmful oligomer species. Once again, there is no direct evidence, clinically or in vivo experimentally to testify to this hypothesis, but it demonstrates the need for informed decision-making in order to avoid maleficence, as according to the primary tenet of medicine, 'first, do no harm'.



Sarah Shah

Figure 1: A model of the Dementia Inclusive Society requires collaboration between scientists, clinicians and policymakers. This is an integrated approach, wherein each level feeds into, affects and is affected by the others. Promotion of this enables dementia inclusive patient-care, beginning at preclinical hypotheses, to patient and family care, alongside readjustment of societal beliefs and infrastructure to accommodate dementia.

Cont.

<u>Target</u>	<u>Name</u>	<u>Mechanism of Action</u>	<u>Estimated End Date</u>
Amyloid	Aducanumab	Monoclonal antibody: A β plaques and oligomers	10/2023
	Lecanemab	Monoclonal antibody: A β protofibrils	08/2024
	Donanemab	Monoclonal antibody: pyroglutamate form of A β	08/2025
	Gantenerumab	Monoclonal antibody: A β plaques and oligomers	10/2026
	Valiltramiprosate	Prodrug of tramiprosate; inhibits A β aggregation into oligomers	05/2024
	Solanezumab	Monoclonal antibody directed at A β monomers	06/2023
Synaptic plasticity/ neuroprotection	AGB101	Reduced A β -induced neuronal hyperactivity via SV2A	12/2022
	Atuzaginstat	Bacterial protease inhibitor targeting gingipain produced by <i>P. gingivalis</i> , reducing neuroinflammation and hippocampal degeneration	12/2022
	Blarcamesine	Sigma-1 receptor agonist, M2 autoreceptor antagonist; oxidative stress, protein misfolding, mitochondrial dysfunction and inflammation	07/2022
	Simufilam	Filamin A protein inhibitor; stabilizes amyloid- α -7 nicotinic receptor interaction	10/2023
Oxidative Stress	Hydralazine hydrochloride	Free radical scavenger	12/2023
	Icosapent ethyl	Purified omega-3 fatty acid EPA; improves synaptic function and reduces inflammation	01/2023
	Omega-3	Antioxidant	12/2023

Metabolism/ bioenergetics	Metformin	Insulin sensitizer to improve CNS glucose metabolism	04/2025
	Semaglutide	GLP-1 agonist; reduces neuroinflammation and improves insulin signalling in the brain	04/2026
	Tricaprilin	Caprylic triglyceride; induces ketosis and improves mitochondrial and neuronal function	03/2024
Proteostasis/ proteinopathies	Nilotinib	Tyrosine kinase inhibitor; autophagy enhancer; promotes clearance of A β and tau	06/2026
Tau	TRx0237	Tau protein aggregation inhibitor	03/2023
Gut-brain axis	GV917	Algae-derived acidic oligosaccharides; reduce peripheral and central inflammation via microbiome	10/2026
Vasculature	Losartan+Amlodipine +Atorvastatin	ANGII receptor blocker, Ca ²⁺ channel blocker, cholesterol agent	01/2022
Inflammation/ Immunity	NE3107	MAPK-1/3 inhibitor; reduces proinflammatory NF κ B activation	01/2023

Table 1: Current phase 3 disease-modifying therapeutics and their mechanisms of action. Modified from (Cummings, J et al. 2022)

2.3. Clinical Implications of Biomarkers as Potential Therapeutic Targets

In addition to utility in research, biomarkers have direct clinical significance in providing targets for novel therapeutics. Clinical trials are carefully monitored and regulated by policy guidelines to ensure efficacy and safety; global initiatives such as the WHO's International Clinical Trials Registry Platform (ICTRP) connect global clinical trial registers to increase accessibility by making information publicly available. This aids in clinical care, improving communication to the public, and streamlines global research collaboration.

As of January 2022, 143 different agents have entered 172 different clinical trials for AD. This includes 31 agents entering phase 3 trial, 82 agents entering phase 2 trials and 30 agents entering phase 1 trials. The nature of these agents differs, from ones which aim to directly modify disease, to those which address alleviation of symptoms via enhancing cognition or treating neuropsychiatric symptoms.

2.4. The Identification of Biomarkers Requires Collaboration Between Research Groups, by Use of Novel Experimental Techniques Informed by Patient Pathologies

Underpinning research to inform clinical-decision making, is the need for novel experimental methods. These allow examination of the brain from individual cell sequencing, to local and long-range circuitry with BOLD fMRI and optogenetics. Novel single-cell genomic strategies, such as drop sequencing (Drop-seq) and microfluidic devices, enable rapid analysis of mRNA transcriptomes to define subgroups of cell populations and characteristics. The development of such technologies for other areas demonstrates the importance of translation within research itself. Applying this technology to varying AD pathology in the prefrontal cortexes of 48 individuals, 80,660 single-nucleus transcriptomes were analysed, identifying subpopulations across 6 major cell types. This provides insight into novel associations for pathophysiology (myelination and differential oligodendrocyte response) and into differential transcription response between the sexes, for example, the overrepresentation of female cells in pathogenic subpopulations. As early pathological progression demonstrates the most change associated with disease, the specificity of this to certain cell-types demonstrates how cellular interrogation of

AD may provide insight for different subgroups within the population. Circuit level analyses can be better understood with cultures or organoids. Cerebral organoids derived from stem cells present opportunities to explore comorbidities, alternatives to the amyloid hypothesis (inflammation, tau pathology), environmental factors and cognitive reserve measurements. Microglial investigation requiring integration of single-cell and whole-circuit analysis, for example, may provide insight into pathological response downstream of amyloid deposition, as ApoE binds to the microglial receptor TREM2, potentially promoting microglial A β uptake. However, limitations of organoid models persist, both in its inability to provide longitudinal data, alongside the ethical challenges that may arise in cultivation of primitive consciousness. Regulation and policy inform this neuroscientific approach. Differential clinical presentations also inform research, by providing various cell lines for examination.

2.5. Stratified Medicine as an Approach to Translate Research: From Bench to Bedside and Beyond

Stratified medicine is present throughout neuroscientific research, as increased specificity in descriptions of dementia states enables translation of science into meaningful clinical relevance. Grouping patients with genetic and molecular techniques enhances care, enabling greater accuracy of diagnosis and increased safety of treatment via precise approaches. For example, a future approach to dementia diagnosis could be the use of in vitro CSF biomarker assays, covering a spectrum of molecular pathophysiological mechanisms. This stratified approach also aids pharmaceutical development, as past failed trials may actually present false positives due to non-specificity of target.

Therefore, stratified medicine may be seen as a method of ameliorating disconnect between dementia in research and clinic. By considering the mechanisms of 'how' in dementia in context of the 'who', therapies can be constructed from the lab upwards with relevant subgroups in mind at every stage. The role of the statistician and dry lab is integral, with 'omic' technologies providing data necessary to make such distinctions. For example, the Lifespan Human Connectome Project-Aging collects fMRI data from over 1200 participants, alongside cognitive, psychiatric and socioeconomic assessments, 600 of which will receive further longitudinal analyses. Publicly accessible data enables predictive modelling of brain ageing, as seen in brain age algorithms which interpret MRI

<u>Reference</u>	<u>Cell Line</u>	<u>Results</u>
Choi <i>et al</i> , 2014	ReN cell VM overexpressing human APP and PSEN1 containing early onset mutations	Inhibition of A β reduces pathology and tauopathy mediated by glycogen synthase kinase 3
Raja <i>et al</i> , 2016	iPSCs derived from 4 early onset patients with APP and PSEN1 mutations	Reduced pathology in patient-derived organoids with β - and γ -secretase inhibitors
Gonzalez <i>et al</i> , 2018	iPSCs derived from an early onset patient with a mutation in PSEN1, and a Down Syndrome patient	Spontaneous development of amyloid plaques and neurofibrillary tangles in pathological organoids
Park <i>et al</i> , 2018	ReN cell VM expressing APP containing young onset mutations, human microglia SV40 cell line, and SCR131 iPSC neural progenitors	Inflammatory pathways; TLR4 knockout models as protective.
Zhao <i>et al</i> , 2020	iPSCs with APOE ϵ 3/ ϵ 3 or ϵ 4/ ϵ 4 genotype from AD patients and individuals with healthy cognition	APOE ϵ 4/ ϵ 4 show decreased synaptic integrity and increased apoptosis
Yin <i>et al</i> , 2021	hPSCs from a familial AD patient displaying PSEN2 ^{N141I} with a wt control generated using CRISPR/Cas9	Neuronal hyperactivity and asynchronous calcium transients.

Table 2: A summary of some cerebral organoids, demonstrating need for patient collaboration in culturing pathological cell lines.

scans to reflect disease risk. A current limitation of this study, however, is failure to demonstrate life-course accumulations of risk. Requiring 80 years of research, appropriate social and ethical policy must ensure the security of participants' data, and ability to consent and participate. The challenges and opportunities of stratified medicine may not be entirely fulfilled at this stage, but it may be considered as one tool to promote the overarching theme of translating neuroscience to integrate with and consider the clinics at every stage, from preclinical hypotheses to wet and dry lab research. Increased public engagement is beneficial in increasing participant retention, while patient interaction motivates researchers. Collaboration facilitates dementia inclusive labs and understanding, from the ground up.

Therefore, stratified medicine may be seen as a method of ameliorating disconnect between dementia in research and clinic. By considering the mechanisms of 'how' in dementia in context of the 'who', therapies can be constructed from the lab upwards with relevant subgroups in mind at every stage. The role of the statistician and dry lab is integral, with 'omic' technologies providing data necessary to make such distinctions. For example, the Lifespan Human Connectome Project-Aging collects fMRI data from over 1200 participants, alongside cognitive, psychiatric and socioeconomic assessments, 600 of which will receive further longitudinal analyses. Publicly accessible data enables predictive modelling of brain ageing, as seen in brain age algorithms which interpret MRI scans to reflect disease risk. A current limitation of this study, however, is failure to demonstrate life-course accumulations of risk. Requiring 80 years of research, appropriate social and ethical policy must ensure the security of participants' data, and ability to consent and participate. The challenges and opportunities of stratified medicine may not be entirely fulfilled at this stage, but it may be considered as one tool to promote the overarching theme of translating neuroscience to integrate with and consider the clinics at every stage, from preclinical hypotheses to wet and dry lab research. Increased public engagement is beneficial in increasing participant retention, while patient interaction motivates researchers. Collaboration facilitates dementia inclusive labs and understanding, from the ground up.

3.1. The Uses and Limitations of Biomarkers in Clinical Diagnoses and Quality of Life Care

These research prospects are translated into clinical diagnostic measures. For example, structural MRI or CT imaging to see brain atrophy, alongside PET radiotracers to determine amyloid and other early biomarkers. CSF biomarkers may also be used in diagnosis, however due to difficulties in access with lumbar punctures, the development of blood biomarkers is a growing area of interest, despite challenges posed by low concentrations (resulting from the blood brain barrier) and increased degradation and clearance. Despite the lack of disease-modifying agents available, tools enabling early diagnoses are crucial in delaying development, allowing people to make decisions for their future care or enter research trials. As preclinical signs may not show cognitive symptoms, biomarker analyses are required. Early diagnoses enable risk-reduction, based upon known factors, such as hypertension, smoking, poor diet, exercise and social habits. In preclinical cases, cognitive reserve improvement increases toleration of pathology without symptoms of cognitive decline; while mechanisms of this are currently unknown, this suggests a need for broader approaches to promote resilience in light of ageing populations. Socioeconomic strategy should explore this, as greater education levels are associated with lower rates of dementia in old age, alongside research studies surrounding neuronal branching and plasticity.

However, this does not undermine difficulties upon receipt of diagnosis. As former consultant obstetrician, Peter Dunlop, stated at the 2013 G8 Dementia Summit: 'Having a diagnosis was a relief tempered by the unknown, having to sort out sudden retirement and finances with an unknown prognosis'. Care goes beyond diagnosis and treatment, and even includes care for the carers involved. From volunteering at a Revitalise Respite Home, offering a holiday experience for patients and carers alike, this improved quality of life both due to offering carers a break, as well as creating opportunities to build upon a relationship outside one of care. Considering how most of the burden falls onto informal carers, such as spouses or relatives, alongside the long nature of the disease, the opportunity for those with dementia to interact with their carers as spouses, children, relatives or friends cannot be overlooked as an important feature of a good quality of life. This may also translate into improved disease prognosis, as social interaction stimulates cognitive reserve. Furthermore, generalist knowledge of palliative care can aid in how we as a society define dementia care and the way this may be stratified to provide effective support to the individual's and family

needs. As a chronic illness, palliative approaches may also benefit patients with young-onset dementia due to the undoubtable psychological impacts of the diagnosis. Randomised control trials of psychosocial intervention were shown to have effects in alleviating the neuropsychiatric symptoms faced by patients.

3.2. The Multifactorial Nature of Elderly and Dementia Care Necessitates the Role of Clinicians in Assessment and Prescription

CASE 1:

A 68-year-old female patient came with concerns of episodic memory impairment, forgetting her grandchildren's names, and disorientation when travelling alone in her town centre. She presented with a high blood pressure, and severe stress and bereavement, alongside caring for her 83-year-old husband. A full ACE test was started, but subsequently abandoned for an MMSE which scored 13/30. CT scans showed minimal ischaemia, alongside a temporal horn above the required range. Despite potential links to vascular dementia, this was determined to be mixed dementia due to her younger age and CT scans being within the Alzheimer's range. As her father was diagnosed with dementia at 70 years old, this may be a sign of AD presenting earlier than normal, with the vascular dementia resulting in the episodic nature of this. As in 2020 she faced equal stress but remained cognitively intact, the change shows that current presentation may not be due to stress alone. Furthermore, signs of the patient being easily overwhelmed which were ascribed to functional psychiatric cause, such as anxiety, may have been symptomatic of dementia. An ECG was requested, with further findings to be taken from there.

CASE 2:

An elderly woman who had previously been assessed with MCI in 2020. Upon arrival, the patient had forgotten that there would be an assessment and was found inappropriately dressed in an untidy house. Through conversation, the patient stated that she was not concerned about her memory, and that she regularly spent time outside and with her neighbours. She exhibited repetitive speech behaviour, and also spoke of having four sons in the present tense, without acknowledgment that one had passed away. Upon speaking to her son, a different story was revealed as the neighbours had not seen her in ~8 weeks. Her MMSE score of 5/30 alongside mild small vessel disease, prominent ventricles and signs of atrophy on CT scan showed rapid progression to mixed dementia since her last assessment. Upon examination, it was revealed that the anticholinergic amitriptyline likely resulted in increasing her confusion. It appears that COVID-19 may have also contributed to slowing down the assessment and referral of this case.

While biomarkers assist diagnoses, they should not undermine the role of the case history and cognitive assessment. For example, while APOE4 has been shown to increase late-onset AD susceptibility, testing for this is not routinely recommended in clinic and requires genetic counselling. Furthermore, not everyone is diagnosed along the same route. Some people may receive support of social services following concerns of their peers, or seek assessment themselves (as above case histories display respectively), others may be referred when seeking treatment for other conditions. For example, within an Elderly and Rehabilitation ward, some patients were referred to seek diagnosis following their inability to perform physical therapy and engage. Dementia is complex by nature of its variability. This is also seen in symptoms, requiring intervention considering all needs of the person as a whole. As Case 1 demonstrates, functional psychiatric conditions such as anxiety or depression may act as confounding variables, with depression as the most common mental health problem in older people. The associations and potentially overlapping pathways of dementia and depression can be seen in how 20% of AD patients and 50% of those with vascular dementia face major depressive disorder, with vascular depression hypothesised as a potential mechanistic pathway, or hippocampal atrophy via impaired negative feedback of the hypothalamic-pituitary axis. This indicates that a combined regimen may be necessary in alleviating dementia and even in the success of a new 'wonderdrug' clinical trial, the multifactorial nature of dementia cannot be ignored.

Furthermore, as Case 2 demonstrates, polypharmacy within older populations is a major concern due to potential iatrogenic consequences, the effects of which are amplified by use of psychotropic drugs. The shift towards defining AD biologically with biomarkers and then giving a novel stratified therapeutic, therefore, is an oversimplified view of dementia treatment. Age related disorders present the unique difficulty of diversity in presentation, to the point where lines between health and disease blur. As a result of this, the role of the clinician appears ever-important in interpretations of cut offs, as well as clinical judgement and experience to prevent iatrogenic or other harmful effects. In addition to this, the process of consultation aids in the social factor of empowering patients, alongside providing

THE 'NICE' GUIDELINES FOR DEMENTIA DIAGNOSIS AND TREATMENT.

[Accessed December 2022, at <https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#diagnosis>]
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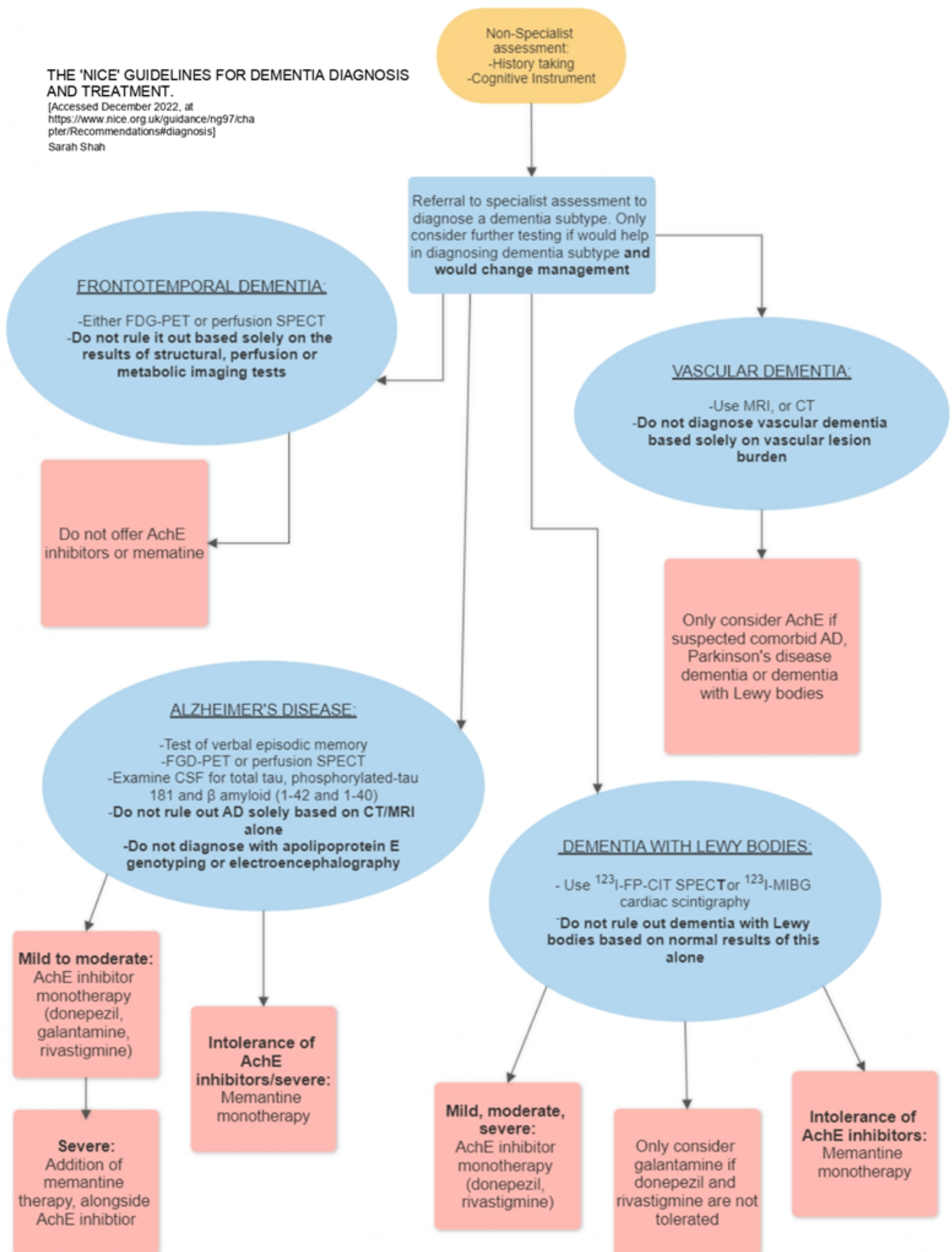


Figure 2: A flowchart demonstrating NICE recommendations of dementia assessment, diagnosis and treatment. This illustrates a rudimentary form of stratification, as patients are subgrouped into different types and severity of dementia, then treated accordingly

holistic assessment. Therefore, the syndromal and biological aspects of dementia should be integrated and utilised together, much like how neuroscience and clinical care should be presented together. This approach already takes place commonly within clinical settings, as doctors are informed by scientific knowledge in their decision, as well as in the Memory Clinic and both cases I have outlined. The usage of biomarkers therefore, will certainly not replace the clinician. Instead, this should provide more precise approaches for intervention and diagnosis. For example, as the current NICE guidelines already exhibit subtyping and categorisation of dementia, arguably a primitive form of stratification, it is clear to see how further scientific research could aid in the knowledge used to inform such guidelines for clinical practice.

4. The Need for Policy in Mediating Integration Between Labs and Clinics to Promote Ethical, Sustainable and Accessible Dementia Inclusive Societies

The importance of policy in mediating the translation between novel therapy into clinical practice cannot be understated. In context of stratified therapy requiring identification of biomarkers within subgroups, how many services have the means to provide PET or CSF testing to make such identification? Policies for standardisation, such as the Global Biomarker Standardisation Consortium for CSF Proteins are first needed to establish references and cut-off levels for routine usage of these technologies. Moreover, even if they are made widely available, does the NHS have the manpower necessary for operation and interpretation? Taking the Memory Clinic I visited, a shortage of clinicians meant that ward patients were shared between different teams and practices, resulting in slow movement and a lack of the stable ward teams needed for effective inpatient psychiatry. It is also worth considering whether clinic structure may face changes to reflect upon subgrouping. Currently, around 1/20 people with dementia are younger than 65, and young-onset patients

may be treated by old age mental health services, as was the case in the service I attended. Data presented in Cambridgeshire shows that while there may not be a requirement for separate services to be created, there should be awareness of the differences between these groups and other categories, such as socioeconomic status. As the Lancet Commission identifies culture, poverty and inequality as key risk factors (alongside alcohol consumption, air pollution, hearing loss and childhood education), targeting these groups would have the most significant impact. Doing this early can increase productivity and independent living, decreasing hospitalisation time therefore decreasing the burden on healthcare. In order for this, policies addressing factors of risk, as well as medical help-seeking behaviour, can enable decreased progression rates of dementia and earlier diagnoses. Moreover, minority group inequalities must be tackled from the research stage: despite chronic age-related disease, such as AD, being more likely to affect minority populations, they are shown to continually face underrepresentation in medical research. Inclusion of these groups in medical research is a crucially needed step, prior to stratification, alongside potential alleviation of disparities by social measures to assess and decrease risk factors.

Stratified approaches are not without fault and in as many opportunities that they offer, they also give rise to potential pitfalls if not managed correctly. In promotion of personalised medical care, implications of consumerism, responsibility and equality arise. As large-scale genetic testing becomes common, with 23&Me offering APOE4 status amongst its database, the general population grows increasingly able to consume healthcare. For AD especially, where the genetic risk may not always correlate with disease presentation, alongside the ability for individuals with higher socioeconomic status to access such services earlier, ethical

considerations are needed. Moreover, direct access to genetic profiles by the individual increases patient responsibility. While the King's Fund does place some responsibility upon the individual for their personal health, increased demand for patients to take such roles in their own health may not be entirely ethical on grounds of further widening disparity gaps and stigmatising healthcare. Considering the legal responsibilities of medical professionals within the UK, increased tools for personal medicine should not replace formalised clinical health structures which are created and maintained by socioeconomic policies.

In light of old age psychiatric care, the specific challenges introduce further areas of consideration. This includes finances, both in terms of funding research for the old as opposed to the young, as well as for the individual who may be susceptible to exploitation. Furthermore, age-discrimination may also be present in increasing reliance on technology, sidelining those who are unable to adapt as 'second-class citizens'. Compounding these two factors, low-financial older populations may be the most at-risk group of inadvertent exclusion. Emotional and functional psychiatric conditions also bear a burden; while successful treatments increase life expectancy of those with dementia, these lives should still be of the highest quality possible. If such treatments are achieved, the increased number of people living with dementia will require conceptual societal shifts, removing negative stereotypes and stigma surrounding the condition. While such changes may not be possible overnight, small steps can be taken today by integrating Dementia Friendly Initiatives into existing structures, for example aiding people with dementia to vote in elections and teaching about dementia in schools. It is evident that policy is paramount to maximising the benefits of new medical fields and strategies, while minimising the potential harms. At this stage, prior to any breakthrough, it is necessary to examine our society for these cracks and put

policies in place that serve to mitigate such problems. Policy can serve to alleviate current issues, such as healthcare inequality or inefficient services, by promoting dementia inclusivity which sets the tone for research and clinical work to be built upon.

5. Conclusion

In conclusion, while some may believe that the application of stratified medical research is the future to dementia diagnosis and therapy, perhaps this is somewhat limited and fails to recognise the need for other factors in facilitating a stratified approach. While the benefits of early stratification can already be seen, stratification alone perhaps would be unable to entirely fulfil its expectations without appropriate scientific knowledge, clinical assessment and regulatory policy. Instead, an integrative approach recognising how dementia exists within the frameworks of society addresses dementia care beyond pharmaceutical and therapeutic treatment. Stratified medicine may serve as a translator between patient, clinic and laboratory to benefit the Dementia Inclusive Society, however this is not the only method of doing so, nor is this the only aim that needs to be addressed. Inclusivity takes a holistic approach, encompassing prevention, treatment and social stability; there are already changes we can make today. Through adoption of dementia friendly labs, clinics and societal institutions (such as schools), we can construct a sustainable model, shifting societal frameworks, and accommodating future breakthrough while advocating for the best quality of life in old age psychiatric care and beyond.

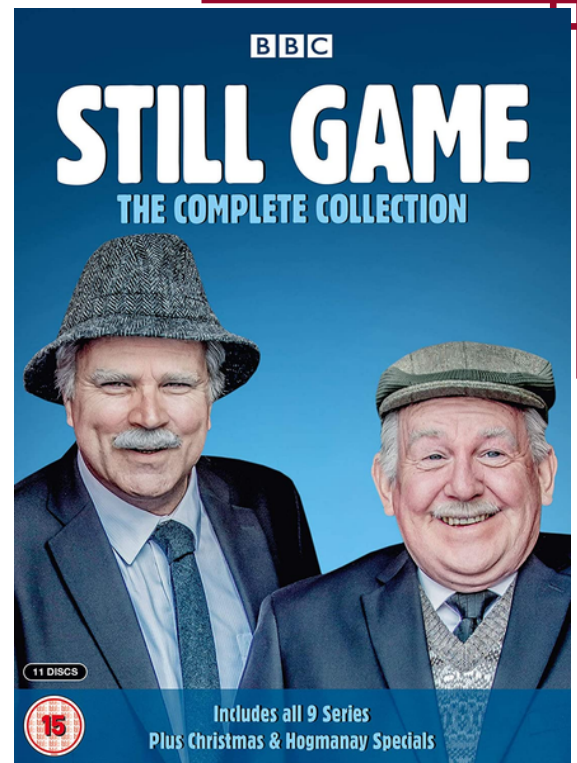
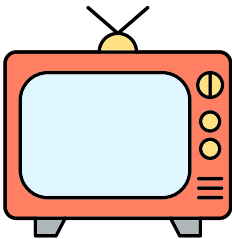
References are available on request

TV Review

Still Game

BBC

Review by Dr Anitha Howard
Consultant Psychiatrist,
Bensham Hospital,
Gateshead



This month's review is a little different-Still Game was a comedy shown on BBC between 2002- 2019. I've chosen this series to review because of the portrayal of older people is unlike anything I've seen before on tv.

Still Game features a cast of actors portraying older adults living in Glasgow, but these older adults aren't your typical older portrayed on TV (although this is changing for the better). These older adults live their lives to the full despite their age, sometimes much more than their younger counterparts.

This has to be one of funniest programmes I have watched but despite the humour the show touches upon some serious issues that older people have to deal with.

The pain of loneliness, your adult children live far away, the limitations of ill-health and poverty, the impact of anti-social behaviour and sexuality in older people rings true despite the humour. The episodes on how older people can't afford to heat their homes during a cold snap and the difficulties the group face when placed in respite felt particularly poignant. But despite this, the residents of Craglaing are not society's victim- the episode where one of the characters takes down a mugger with his false leg remains one of my favourite episodes.

I would recommend watching Still game to anyone who wants a good laugh but also to anyone who appreciates well scripted television featuring a group of talented actors.

Still Game is streaming on Netflix at the time of publication of the newsletter.

Trainee Focus



Welcome back to your trainee focused section of the OA faculty newsletter. Since last edition we have had a change in the team, we have said a fond farewell to Funmi who has gone on to Consultant working and have welcomed Becky Fitton, who was successful in her application to become a Higher Trainee representative. Firstly an introduction from Becky and then on to our focus for this edition: clinical leadership.

"Hello, I'm Becky Fitton, I'm an ST6 in Yorkshire and Humber training less than full time (80%). I'm a dual trainee in old age and general adult psychiatry but I've become convinced that old age psychiatry is the best specialty! I have a particular interest in liaison and neuropsychiatry. I am delighted to join the faculty as trainee rep, I'm particularly looking forward to helping plan the trainee conference at the end of the year".

Lizzie and Becky

TO TRAINEES IN THE OLD AGE FACULTY WE
HAVE AN EXCITING OPPORTUNITY FOR YOU

TRAINEE EDITOR THE OLD AGE PSYCHIATRIST NEWSLETTER

Consider applying if you are enthusiastic, creative and organised with an interest in Old Age Psychiatry, and you are looking for a new and exciting opportunity to develop leadership and publication skills.

This post would begin from September 2023 for 1 year

To apply please email lead editor, Dr Sharmi Bhattacharyya, c/o Kitti.Kottasz@rcpsych.ac.uk with a statement expressing your interest by 15th June 2023

For more information you can contact the current Trainee Editor Dr Anne M. Bonnici Mallia, c/o Kitti.Kottasz@rcpsych.ac.uk

Trainee Focus

Higher Trainees: The clinical leaders of the future

Dr Rebecca Fitton - RCPsych Old Age Faculty Executive Trainee Representative
ST6 Dual Old Age and General Psychiatry, Yorkshire and the Humber Training Scheme
rebecca.fitton1@nhs.net

Dr Elizabeth Robertson - RCPsych Old Age Faculty Executive Trainee Representative
ST5 Old Age Psychiatry, Scotland National Training Scheme (SE)
e.robertson@nhs.scot

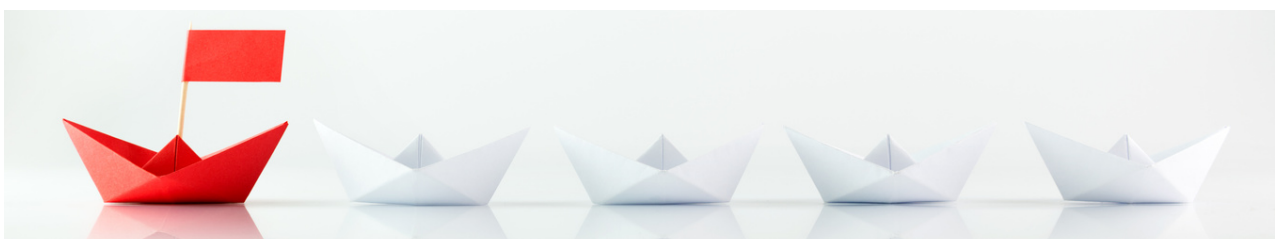
Higher training is a great opportunity, now that exams are completed, to really focus on expanding your skill set as a clinician. Whether we like it or not, medics and especially Consultants within MDTs are viewed as clinical leaders. Themes 5.1 "Teamworking" and 5.2 "Leadership" in our new curriculum includes key capabilities of being able to negotiate, manage conflict, support and develop the practice of other team members, prioritise and delegate effectively. We must demonstrate an inclusive leadership style with awareness of the impact of hierarchy. It is also essential to gain feedback on our practice and be able to adapt and develop in response to this. You may not realise it but it is likely you will be engaging in many of these activities already. We hope to highlight below the opportunities available to develop and evidence these skills both in your day to day practice and via more formal training.

Developing leadership capabilities during your day job

One of the most easily accessible leadership opportunities is to practice leading ward rounds, referral meetings and multidisciplinary team meetings. This can be used as the basis for a DONCS (Direct observation of non-clinical skills) to provide evidence for your portfolio. It can feel intimidating to attempt to take on a leadership role within the team, particularly when you are rotating into a new department you haven't worked in before. Remember that leadership is not about having all the answers, rather it is about guiding the direction of the team, encouraging communication and collaborative decision making and ensuring every team members' skills are used to their best advantage.

Working within an MDT also provides great opportunity for requesting feedback on your practice, for example via a mini-PAT. You can then reflect on any areas for development from this in your portfolio and discuss with your supervisor in supervision.

Other day-to-day opportunities include attending departmental or directorate management meetings to observe how service decisions are made and even being part of an interview panel for a team vacancy.



Trainee Focus

Leading a service improvement project

As trainees we will work across many different teams over the course of training. Whilst the frequent rotations can make it more challenging to settle into a post long enough to feel confident leading change, our breadth of experience gives us a unique perspective on how different teams work. This allows us to provide a fresh pair of eyes to see where service improvements can be made.

“Whilst working in memory clinic I realised that our service wasn’t doing the recommended pulse monitoring after starting people on acetylcholinesterase inhibitors....the nursing staff did not feel confident that they knew how to manage patients who were bradycardic so I developed some guidelines with a flow chart for them to follow. It was only a small intervention but it was great to feel that I had contributed something significant and it helped me feel more embedded in the team.”

- ST4 trainee, North Yorkshire

Shadowing opportunities

Shadowing senior managers and leaders (both clinical and non clinical) within your organisation, such as the medical director or chief executive can be helpful in understanding the management structure of the trust. It gives you an opportunity to observe different leadership styles and reflecting what you wish to take forward into your practice.

“I shadowed the medical director for three months, attending meetings of the trust executive board and committees...I gained insight into how the leadership structure of the trust influences daily activities and responds to challenges like staffing, facilities and industrial action. It’s useful to have a relationship with managers as you progress in your career especially when preparing for consultant interviews”.

- Dr Babajide Adeyefa, ST6/Acting Consultant, Leeds

Helpful Resources

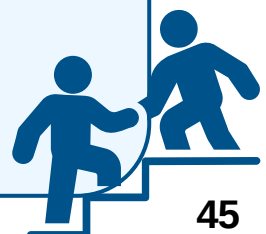
Royal College of Psychiatrists - Curricula documents and resources

Royal College of Psychiatrists - Leadership development

Faculty of Medical Leadership and Management - How to chair a meeting

Faculty of Medical Leadership and Management -
Gaining exposure to medical leadership

NHS Scotland - Leadership and management programmes



Trainee Focus

Formal leadership and management training

Local training bodies and trusts or health boards often provide leadership and management courses which can be attended using study leave and funding if required and we recommend looking into this via their websites, or contacting your TPD and other local trainees.

One example is the NHS Education for Scotland [Leadership and Management Programme](#). Nationally the [NHS Leadership Academy](#) provides a range of courses, starting with the Edward Jenner programme, which is free to access. As a higher trainee you could use your professional development (special interest) sessions to pursue this further. There are also possibilities to pursue further qualifications such as a PGCert in medical or healthcare leadership.

“I used my special interest sessions to complete the Mary Seacole programme through the NHS leadership academy. It covered areas like how to create successful teams, developing negotiating skills and leading service improvement as well as practical things like understanding finances in the NHS and managing disciplinary issues. It was mainly online learning but we had several study days and it was useful to meet with peers from lots of different professions within the NHS as it gave me a wider perspective on how everything fits together”.

- ST5 Trainee, West Yorkshire

Fellowship schemes, such as the [RCPsych Leadership and Management Fellow Scheme](#) support you to work on a local leadership project whilst providing training and mentoring both locally and nationally. This scheme works alongside your training, using professional development sessions over a 12 month period. Closing date for the 2023/24 scheme is 4th May.

“I undertook the Royal College of Psychiatrists Leadership and Management Fellowship Scheme. It uses a combination of structured leadership development programmes and a local apprenticeship model, utilising special interest time over 12 months....(your) trust has to agree to sponsor you financially and support you by providing a mentor for your chosen project. I found the scheme extremely rewarding and benefited from the interactions with experienced leaders from various organisations. It was also an excellent way to learn from what was happening in other areas through structured peer support”.

- Dr Christiana Elisha-Aboh, ST7 York

Looking forward

We hope this has given you some ideas to take forward and allowed you to reflect on your position as a clinical leader. We are keen to hear from you with any ideas, requests or contributions you may have for future editions of trainee focus. You're welcome to get in touch.

